

6621

CERTIFICATE OF DEATH

06598

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover Md.</u>			
c. LENGTH OF STAY IN 1b <u>9 Days</u>				d. STREET ADDRESS <u>5621 Landover Road</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Girl</u> Last <u>Ammonn</u>				4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>19 57</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 20 1957</u>	
9. AGE (In years last birthday) <u>9 Days</u>		10. IF UNDER 1 YEAR Months <u>9</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		11. BIRTHPLACE (State or foreign country) <u>Cheverly Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>Clyde E. Ammonn</u>				14. MOTHER'S MAIDEN NAME <u>Ada V. Beall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. -----		17. INFORMANT <u>Ada (Mother) Ammonn</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal Obstruction</u> DUE TO <u>Congenital atresia of duodenum - jejunal</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u>from birth</u>				INTERVAL BETWEEN ONSET AND DEATH <u>9 11</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I attended the deceased from <u>6-23-1957</u> to <u>6-28-1957</u> , that I last saw the deceased alive on <u>6-28-1957</u> , and that death occurred at <u>3:20 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. Geo H. McLain</u> M.D.				ADDRESS (Street, city or town, state) <u>1746 K St. N.W.</u> DATE SIGNED <u>WAS H-67D.C</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Geo H. McLain</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/29/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ammondale Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Ammondale, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James March's Sons</u>				ADDRESS <u>4739 Baltimore</u>		24a. REC'D BY REGISTRAR <u>Jul 3 57</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. March</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2077386XV3

CERTIFICATE OF DEATH

BUREAU V. 2

8 1957

RECEIVED

6622

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 14, 8, & 22C Film G-217 7/1/57 **CERTIFICATE OF DEATH**

Reg. Dist. No. 06599

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE MD b. COUNTY PG			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY ATTSTREE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 HYATTSVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEO. GEN HOSP				e. STREET ADDRESS 6903-18 AVE			
3. NAME OF DECEASED (Type or print) First Middle Last HAROLD M. ANDERSEN				4. DATE OF DEATH Month Day Year JUNE 10 1957			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1903 10-17-102	9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. COAST GUARD		10b. KIND OF BUSINESS OR INDUSTRY MARINE AGR		11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gunder Andersen				14. MOTHER'S MAIDEN NAME Ellen Marie Evenson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Wilson, N.C. Mr. Harold J. Andersen 1121 N. Bynum St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 ACUTE HEART FAILURE DUE TO ACUTE MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) 7 DAYS 1 MONTH						INTERVAL BETWEEN ONSET AND DEATH 2 HOURS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month. Day. Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from JUNE 3, 1957 to JUNE 10, 1957 that I last saw the deceased alive on JUNE 10, 1957 , and that death occurred at 2 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Samuel J. Sugar				DATE SIGNED 6/10/57			
PHYSICIAN'S NAME (Type) SAMUEL J. N. SUGAR, M.D.				ADDRESS (Street, city or town, state) 714 RAINIER, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6/12/57		22c. NAME OF CEMETERY OR CREMATORY Forest Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Milwaukee, Wisconsin	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Company Washington, D.C.				24a. REC'D BY REGISTRAR DATE JUN 12 57		24b. REGISTRAR'S SIGNATURE Paul	

CERTIFICATE OF DEATH

BUREAU V. 3

JUN 12 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. To burial, cremation, or removal, file pages 1 and 2 with the registrar.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
6692					06600					
					Reg. Dist. No.					
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE D.C. b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale			c. LENGTH OF STAY IN 1b transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Baltimore- Washington Parkway					d. STREET ADDRESS 2224- 1st Street					
3. NAME OF DECEASED (Type or print) First Nealy Middle James Last Anderson					4. DATE OF DEATH Month June Day 9 Year 1957					
5. SEX Male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 22, 1929		9. AGE (in years last birthday) 28 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lubrication man		10b. KIND OF BUSINESS OR INDUSTRY Auto. service.		11. BIRTHPLACE (State or foreign country) S. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Nealy Alexander					14. MOTHER'S MAIDEN NAME Carrie Anderson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes.		16. SOCIAL SECURITY NO. 219-40-4260		17. INFORMANT Mrs. J.M. McClurkin; same address.		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhage and shock 816X DUE TO Severence of thoracic aorta Conditions, if any, which gave rise to immediate cause (b) Severence of thoracic aorta (c) Severence of thoracic aorta DUE TO Severence of thoracic aorta (c) Severence of thoracic aorta										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of an automobile in collision with another automobile							
20c. TIME OF INJURY Month, Day, Year Hour 11:50 P.M. 6-8-57			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Glenn Dale, Pr. Geo. Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE John T. Maloney					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) John T. Maloney, M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER Rx June 9, 1957					
22a. BURIAL, CREMATION, REMOVAL (Specify) 6/11/57		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City, town, or county) (State) SPARTANSBURG S.C.			
23. FUNERAL DIRECTOR'S SIGNATURE FRAZER'S FUNERAL HOME 389 RT					ADDRESS		24a. REC'D BY REGISTRAR June 12 '57		24b. REGISTRAR'S SIGNATURE W. L. Smith	

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of deceased: James M. Smith
2. Date of death: 1957-1-10
3. Place of death: Home
4. Age: 45
5. Sex: Male
6. Race: White
7. Occupation: Engineer
8. Cause of death: Heart disease
9. Manner of death: Natural
10. Signature of Medical Examiner: [Signature]
11. Date of certification: 1957-1-15

BUREAU V. 3

JUN 12 1957

RECEIVED

6623

CERTIFICATE OF DEATH

06601

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MD b. COUNTY PG			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverley				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Kent Village			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Gen Hosp				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Neva F Anderson				4. DATE OF DEATH Month Day Year June 4 1957			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 9, 1900	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) south Dakota		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Charles A. Horning				14. MOTHER'S MAIDEN NAME ella Rose			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —		17. INFORMANT Address Marion L. Anderson Kent village Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive, interventricular hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Essential hypertension 109X DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 444X 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 6/4, 1957, to 6/4, 1957, that I lost saw the deceased olive on 6/4, 1957, and that death occurred at 8:20 AM, from the causes and on the date stated above. ADDRESS (Street, city or town; state) DATE SIGNED 3404 Cheverley ave Cheverley Md 1/4/57 ACTUAL SIGNATURE John Kehoe M.D. PHYSICIAN'S NAME (Type) JOHN KEHOE Cheverley Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 6, 1956		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va	
23. FUNERAL DIRECTOR'S SIGNATURE F Buschi sons Hyattsville Md				24a. REC'D BY REGISTRAR JUN 10 57		24b. REGISTRAR'S SIGNATURE C. L. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple lines for handwritten information, including fields for name, age, sex, race, date of death, and cause of death. The handwriting is mostly illegible due to fading.

BUREAU V. 2

JUN 10 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

6624

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06602

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>				d. STREET ADDRESS <u>4104 53rd Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Harvey</u> Last <u>Baird</u>		4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>19 57</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-23-36</u>	9. AGE (In years last birthday) <u>20</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Harvey Lee Baird</u>			14. MOTHER'S MAIDEN NAME <u>Mary M Jones</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mother ; same address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> <u>823X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Crushed chest and lacerated wound of abdomen</u> (c) <u> </u> DUE TO (a) stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Collision of automobile with an embankment</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>10.35</u> P.M. <u>6-23</u> <u>1957</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Glenn Dale, Pr. Geo. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John T. Maloney</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/26/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Andrews</u>		22d. LOCATION (City, town, or county) (State) <u>Buckingham Co Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Guack's sons Hyattsville Md</u>				24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

MEDICAL CERTIFICATION

DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

REPORT OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

JUN 27 1957

RECEIVED

6625

CERTIFICATE OF DEATH

06603

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 1 da. 19 hr. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant d. STREET ADDRESS 6815 EADS Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last Adelaide FLORENCE Barnes				4. DATE OF DEATH Month Day Year June 25 1957			
5 SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-21-78	
9. AGE (In years last birthday) 79		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) asst. Chief	
10b. USUAL BUSINESS OR INDUSTRY 21. Printing office		11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Joseph W. Palmer	
14. MOTHER'S MAIDEN NAME Mary Steele		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Marilyn Stewart Address 1610 - Myrtle St. N.W.	
18 CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary arterio sclerosis DUE TO (c) Generalized arterio sclerosis							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Seat Pleasant				20g. (County) Prince Georges		20h. (State) Maryland	
21. I certify that I attended the deceased from Jan 10 , 19 50 , to June 25 , 19 57 , that I last saw the deceased alive on June 25 , 19 57 , and that death occurred at 12 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE William Brainin				ADDRESS (Street, city or town, state) 6124 Central Ave			
PHYSICIAN'S NAME (Type) WM BRAININ				DATE SIGNED 6/25/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-28-57		22c. NAME OF CEMETERY OR CREMATORY Washington Natl.		22d. LOCATION (City, town, or county) (State) Seat Pleasant Maryland	
23 FUNERAL DIRECTOR'S SIGNATURE W. W. Chamberlain				ADDRESS 577-11th St. S.E.		24a. REC'D BY REGISTRAR DATE JUN 28 57	
				24b. REGISTRAR'S SIGNATURE Rebecca			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed with n 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 28 195

BUREAU V. S.

6626

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 34 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Carl M Bavone		4. DATE OF DEATH Month Day Year June 23 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 June 1908
9. AGE (In years last birthday) 49 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer Government	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Fred Bavone		14. MOTHER'S MAIDEN NAME Emilia Poli	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO 1 11	
17. INFORMANT Lena A Bavone		Address 3402 Notre Dame St University Hills, Md.	
18. CAUSE OF DEATH [Enter only one cause per line (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adenocarcinoma of Stomach DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 19 56, to June 22 19 57, that I last saw the deceased alive on June 22 19 57, and that death occurred at 5:30 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Leon Lawrence Gallin M.D.		ADDRESS (Street, city or town, state) 7206 Cokerhill Rd University Hills Md	
DATE SIGNED 6/23/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/26/56	22c. NAME OF CEMETERY OR CREMATORY St Barnards Cemetery
22d. LOCATION (City, town or county) Indiana		(State) Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE JUN 26 57	
		24b. REGISTRAR'S SIGNATURE W. H. H. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. B.

3 1957

RECEIVED

6627

CERTIFICATE OF DEATH

06605

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Md.</u>			
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>				d. STREET ADDRESS <u>4216 Jefferson St</u>			
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Beatty</u> Middle <u>Beatty</u> Last <u>Beatty</u>				4. DATE OF DEATH <u>June</u> Month <u>14</u> Day <u>1957</u> Year			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 20 1875</u>	
9. AGE (in years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Samuel J. Beatty</u>				14. MOTHER'S MAIDEN NAME <u>Annie E. Wise</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Manie L Beatty</u> Address <u>Hyattsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>INTRACEREBRAL Hemorrhage</u>							<u>48 hrs</u>
DUE TO (b) <u>cerebral Arteriosclerosis</u>							<u>5 yrs</u>
DUE TO (c) <u>generalized Arteriosclerosis</u>							<u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4570</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MARCH 31, 1957</u> to <u>JUNE 14, 1957</u> , that I last saw the deceased alive on <u>JUNE 14, 1957</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Norman Donat Comeau</u> M.D. <u>3503 Penny St</u>				DATE SIGNED <u>6/14/57</u>			
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT COMEAU</u> <u>MT RAINIER MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/17/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>1. Gasch's Sons</u> ADDRESS <u>Hyattsville, Maryland.</u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>JUN 19 57</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. H.

JUN 19 1957

RECEIVED

6628

CERTIFICATE OF DEATH

06606

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Bowie George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase 15</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Leland Memorial Hosp</u>		d. STREET ADDRESS <u>4316 Willow Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Linda g. Blackistone</u>		4. DATE OF DEATH <u>6</u> Month <u>21</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 15, 1955</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Zachariah Blackistone</u>		14. MOTHER'S MAIDEN NAME <u>Harriet J. Atwell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Zachariah D. Blackistone-Same Item #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>481X</u> DUE TO <u>Delirium Tremens and Acetaminophen</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Upper Respiratory Infection</u> (c) <u>24 h</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m p m <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 17</u> , 19 <u>57</u> to <u>June 21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 21</u> , 19 <u>57</u> , and that death occurred at <u>3:57</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>311 Thos. Drive, Laurel, Md.</u> DATE SIGNED <u>6/21/1957</u>			
ACTUAL SIGNATURE <u>Robert C. Wingfield</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Robert C. Wingfield</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/25/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert C. Wingfield</u>		24a. REC'D BY REGISTRAR <u>JUN 26 1957</u>	24b. REGISTRAR'S SIGNATURE <u>James H. Jones</u>

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

JUN 26 1957

RECEIVED

6629

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66697

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Dist. of Col. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 501 11th Street, N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Robert Frank Blasdell		4. DATE OF DEATH Month Day Year June 24 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 20, 1931
9. AGE (In years last birthday) 25 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plastic engineer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Bu. of Ships	
11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Vernell G. Blasdell		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) Korean		16. SOCIAL SECURITY NO.	
17. INFORMANT Beverly Blasdell; Same address		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock			
DUE TO (b) Fractured skull			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Rider of a motorcycle which overturned throwing him to the pavement	
20c. TIME OF INJURY Month, Day, Year 12. 35 6- 23- 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Riverdale Fr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED June 24, 1957	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/27/57	
22c. NAME OF CEMETERY OR CREMATORY Washington National		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE James S. Sone Hyattsville, Md.		24a. REC'D BY REGISTRAR June 26 '57	
24b. REGISTRAR'S SIGNATURE DeLoach			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

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RECEIVED

6630

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE MD. b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SEAT PLEASANT	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGES GEN. HOSP.		d. STREET ADDRESS 7004 ROLAND RIDGE DRIVE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle WILLIAM Last BOWEN		4. DATE OF DEATH Month JUNE Day 16 Year 19 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-5-57
9. AGE (In years last birthday) yrs. 5		IF UNDER 1 YEAR: Months 5 Days 11 Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John William Bowen		14. MOTHER'S MAIDEN NAME Dolores Welch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT John William Bowen		Address 7004-Rolling Ridge	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congenital heart failure			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Ischemic & I.V. pyelonephritis			
DUE TO (c) Defect & abnormal anatomy & put into rd at time			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/16 , 19 57 , to 6/16 , 19 57 , that I last saw the deceased alive on 6/16 , 19 57 , and that death occurred at 1:50 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Max W. Herzberg		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) MAX HERZBERG			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	6-19-57	Carroll Hill Cem.	Seat Pleasant, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers, S.E.		24a. REC'D BY REGISTRAR 18 57	
ADDRESS Wash D.C.		24b. REGISTRAR'S SIGNATURE Outen	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar to burial, cremation, or removal, and in any event within 72 hours after death.

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RECEIVED

JUN 18 1957

BUREAU OF

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06699

6631

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Penna. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg, Md.		c. LENGTH OF STAY IN 1b 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Philadelphia			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2011 Kenilworth Avenue				d. STREET ADDRESS 1543 North 18th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Deloris Middle Breland Last Breland				4. DATE OF DEATH Month June Day 20 Year 1957			
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25, 1940	9. AGE (In years last birthday) 17 yrs.	IF UNDER 1 YEAR Months 17 Days 20 Hours 20 Min 57	IF UNDER 24 HRS. Months 17 Days 20 Hours 20 Min 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY school		11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Joe Breland				14. MOTHER'S MAIDEN NAME Idell Hines			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Idell Breland Philadelphia Penna.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Universal 3rd and 4th degree burns of body DUE TO (c) Conflagration in home							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Overcome by smoke and burned by fire in home.					
20c. TIME OF INJURY Month, Day, Year Hour 6:20 P. M. 6-20-57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hyattsville P.O. Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 20, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-26-57		22c. NAME OF CEMETERY OR CREMATORY Washington National		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Maloney				ADDRESS 1722 7th St		24a. REC'D BY REGISTRAR John T. Maloney	
				24b. REGISTRAR'S SIGNATURE John T. Maloney		DATE June 27 1957	

BUREAU V S.

JUN 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for use in the burial, cremation, or removal, and in any event within 72 hours after death.

6632

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 File 23 8-1-57 et

CERTIFICATE OF DEATH

06610

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale Md		c. LENGTH OF STAY IN 1b 10 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 25 Riverdale Md.		d. STREET ADDRESS 6107 63rd Avenue.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6107 63rd Avenue.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Winfield S Brickerd		4. DATE OF DEATH Month Day Year June 10, 1957.	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 26
9. AGE (In years last birthday) 76 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Tile Setter	11. BIRTHPLACE (State or foreign country) Maryland
10b. KIND OF BUSINESS OR INDUSTRY self		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Isaac Brickerd		14. MOTHER'S MAIDEN NAME Sidney ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 17. INFORMANT Ida A Brickerd Riverdale, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 120.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden death 6 weeks arterio sclerotic heart disease - 6 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 7, 1957, to June 10, 1957, that I last saw the deceased alive on June 7, 1957, and that death occurred at 12:45 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE L W Malin M.D.		DATE SIGNED June 11, 1957	
PHYSICIAN'S NAME (Type) L W Malin M.D.		ADDRESS (Street, city or town, state) Riverdale, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/13/57	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.		24. REC'D BY REGISTRAR 25. REGISTRAR'S SIGNATURE James L. Jones	

BUREAU Y. E.

JUN 14 1957

RECEIVED

6633

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRINCE GEORGES</u>		d. STREET ADDRESS <u>36-4th STREET</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ambrose E. Brown</u>		4. DATE OF DEATH Month Day Year <u>June 2 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-11-75</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Parkman, Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dist of Columbia</u>	11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>unknown</u>	
14. MOTHER'S MAIDEN NAME <u>unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>no</u> (If yes, give year or date of service) <u>none</u>	
16. SOCIAL SECURITY NO <u>yes</u>		17. INFORMANT Address <u>Mrs Achsah Brown 36 4th St Laurel, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>4 to 5</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized Arteriosclerosis</u> DUE TO <u>10 years</u> (c) <u>Hypertensive Cardio Vascular Disease</u> <u>10 years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5/31</u> , 19 <u>57</u> , to <u>6/2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/2</u> , 19 <u>57</u> , and that death occurred at <u>3:57</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Norman Donat Omeau</u> M.D.		ADDRESS (Street, city or town, state) <u>3503 Penny St</u> DATE SIGNED <u>7/2/57</u>	
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT OMEAU</u>		<u>MT RAINIER MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-5-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Gaithersburg, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co</u> ADDRESS <u>Riverdale, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 6 '57</u>	24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 6 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 3 should be filled with the registrar's name, to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6634

CERTIFICATE OF DEATH

06612

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u>		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PR. GEO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BLADENSBURG</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BLADENSBURG</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>4116-51ST STREET</u>	
3. NAME OF DECEASED (Type or print) <u>SARAH E. BUTLER</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>30</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-19-1904</u>
9. AGE (In years last birthday) <u>53</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>UNKNOWN</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>CHAS. HEBBURN</u>	
14. MOTHER'S MAIDEN NAME <u>CATHERINE JACKSON</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>CHARLES H BUTLER</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocarditis</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 Yrs</u> <u>5 Yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>443.3</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p. <u>19</u> Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/10</u> , 19 <u>57</u> to <u>6/30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/28</u> , 19 <u>57</u> , and that death occurred at <u>10 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>H yattsville Md.</u> DATE SIGNED			
ACTUAL SIGNATURE <u>Leonard Hays</u> M.D.		PHYSICIAN'S NAME (Type) <u>Leonard Hays M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/3/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Memorial</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Blair Stewart</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 2 '57</u>	24b. REGISTRAR'S SIGNATURE <u>Blair Stewart</u>

BUREAU V. S.

APR 2 1957

RECEIVED

6635

CERTIFICATE OF DEATH

06613

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE Md. b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md.				c. LENGTH OF STAY IN 1b 1 Day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				d. STREET ADDRESS Landover Hills, Md			
3. NAME OF DECEASED (Type or print) First Maggie Middle A. Last Causey				4. DATE OF DEATH Month June Day 8 Year 19 57			
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 4, 1874	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME David Aiken				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs Eula Rutledge Landover Hills, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month, Day, Year 19 57	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from 6/7/57 19 56 to 6/8/57 19 56 that I last saw the deceased alive on 6/8/57 19 57 , and that death occurred at 9:25 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2409 Vassar St DATE SIGNED 6/8/57 ACTUAL SIGNATURE [Signature] M.D. Landover Hills, Md. PHYSICIAN'S NAME (Type) Dr. F. Musser							
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation		22b. DATE THEREOF 6/9/57	22c. NAME OF CEMETERY OR CREMATORY Greensboro		22d. LOCATION (City, town, or county) (State) North Carolina		
23. FUNERAL DIRECTOR'S SIGNATURE F. Gatch's Sons Hyattsville, Maryland.				24a. REC'D BY REGISTRAR DATE JUN 12 57		24b. REGISTRAR'S SIGNATURE [Signature]	

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JUN 12 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06614

6612

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville		c. LENGTH OF STAY IN 1b 12 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3304 Lancer Drive		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Grace Last Cipriano		4. DATE OF DEATH June 26, 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 16, 1957
9. AGE (In years last birthday) 3/12 yrs.		10. IF UNDER 1 YEAR Months 3 Days 12 Hours 12 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MICHEL CIPRIANO		14. MOTHER'S MAIDEN NAME Rita E. Taylor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —	
17. INFORMANT Rita E. Taylor		Address Greenbelt, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) VASCULAR COLLAPSE. 101X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) INCREASED INTRACRANIAL PRESSURE DUE TO (c) HYDROCEPHALUS + MENINGOCELE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) LIFE (b) LIFE (c) LIFE			INTERVAL BETWEEN ONSET AND DEATH 30 MIN.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour — Month — Day 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6/22 , 19 57 , to 6/26 , 19 57 , that I last saw the deceased alive on 6/22 , 19 57 , and that death occurred at 11:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph J. McDonald M.D.		ADDRESS (Street, city or town, state) JOSEPH J. McDONALD, M.D. 7300 RIGGS ROAD UNIVERSITY CITY APTS. W. HYATTSVILLE, MD.	
PHYSICIAN'S NAME (Type) —		DATE SIGNED 6/26/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/27/57	22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Washington D. C.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.		24a. REC'D BY REGISTRAR JUN 28 1957	
ADDRESS —		24b. REGISTRAR'S SIGNATURE James Seary	

RECEIVED
JUN 28 1957
BUREAU V. S.

6636

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT. RAINIER</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRINCE GEORGES GEN. HOSP.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BARRY BOY COSTELLO</u>		4. DATE OF DEATH <u>June 28 1957</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 23 1957</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Cheverly, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Joseph Louis Costello Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Tranth</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>162.5 Atelectasis</u> DUE TO (b) <u>Prematurity</u> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/23, 1957</u> , to <u>6/23, 1957</u> , that I last saw the deceased alive on <u>6/23, 1957</u> , and that death occurred at <u>11:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles C. Hageage</u>		ADDRESS (Street, city or town, state) <u>mt. Rainier</u>	
PHYSICIAN'S NAME (Type) <u>CHARLES C. HAGEAGE</u>		DATE SIGNED <u>md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>6/25/57</u>	<u>mt. Olive</u>	<u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Halley's Funeral Home, Inc.</u>		24a. REC'D BY REGISTRAR <u>mt. Rainier</u>	24b. REGISTRAR'S SIGNATURE <u>md.</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

JUN 27 1957

RECEIVED

6637

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 11 Hrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS Upper Marlboro			
3. NAME OF DECEASED (Type or print) First Baby Middle Girl Last Curtis				4. DATE OF DEATH Month June Day 2 Year 19 57			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 June 1957		9. AGE (In years last birthday) yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---			10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Frederick Curtis				14. MOTHER'S MAIDEN NAME Irene Burroughs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Frederick Curtis Address Upper Marlboro, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 762.5 Atelectasis DUE TO (b) Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) Prematurity							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18.]				
20c. TIME OF INJURY Hour 19 o. m. p. m.	Month June Day 2 Year 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hyattsville, Md.		(County) (State)
21. I certify that I attended the deceased from June 1, 1957 , to June 2, 1957 , that I last saw the deceased alive on June 2, 1957 , and that death occurred at 7,30 A.M. , from the causes and on the date stated above.							DATE SIGNED 6/5/57
ACTUAL SIGNATURE J. Perkins			ADDRESS (Street, city or town, state) 5301 Hamilton St., Hyattsville, Md.				
PHYSICIAN'S NAME (Type) J. Perkins			5301 Hamilton St., Hyattsville, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/4/57	22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		22d. LOCATION (City, town, or county) (State) Upper Marlboro, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Upper Marlboro, Md.				24a. REC'D BY REGISTRAR JUN 6 '57		24b. REGISTRAR'S SIGNATURE W. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 6 1957

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

6638

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06617

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution, residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John Joseph Dailey</u>				4. DATE OF DEATH <u>June 7 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 12 1907</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS. Hours Min		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Dailey</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes/no or unknown) <u>Yes</u> <u>WW II</u>				16. SOCIAL SECURITY NO. <u>589-07-188</u>			
17. INFORMANT <u>Mary Dailey</u> Address <u>same as #2</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u> DUE TO (b) <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>6-11-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Fort Myer, Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Mattingly</u> ADDRESS <u>Wash DC</u>				24a. REC'D BY REGISTRAR <u>John A. Mattingly</u> DATE <u>JUN 12 57</u>		24b. REGISTRAR'S SIGNATURE <u>John A. Mattingly</u>	

DATE SIGNED

June 7, 1957

RECEIVED
JUN 12 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6639

CERTIFICATE OF DEATH

Reg. Dist. No.

06618

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cheney</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George Gen. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last RICHARD T. DARMOHRAY Jr.				4. DATE OF DEATH Month Day Year June 18th 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31st-1956	9. AGE (In years last birthday) yrs. 20	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard T. Darmohray				14. MOTHER'S MAIDEN NAME Lois H. King			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Richard T. Darmohray- 32-E-Crescent Dr. Greenbelt, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory failure, + Cardiac failure</i> DUE TO <i>Central Cerebral palsy + ulcer.</i> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. <i>7/5X</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Trophic peptic ulcer</i> INTERVAL BETWEEN ONSET AND DEATH <i>16-24 months</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6-17</i> 19 <i>57</i> to <i>6-18-57</i> that I last saw the deceased alive on <i>6-18-57</i> 19 <i>57</i> and that death occurred at <i>6:30 PM</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>3001-Cheverly Ave., Cheverly, Md.</i> DATE SIGNED <i>6-18-57</i>							
ACTUAL SIGNATURE <i>B. Van Gelderen</i> M.D.				3001-Cheverly Ave., Cheverly, Md.			
PHYSICIAN'S NAME (Type) Dr. Bertha Van Gelderen				3001--Cheverly Ave., Cheverly Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-20-57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Seimons Bros.</i> 1661--Good Hope Rd., SE Washington, DC				24a. REC'D BY REGISTRAR DATE JUN 20 57		24b. REGISTRAR'S SIGNATURE <i>Reed</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar and to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. NAVY

JUN 26 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

6640

1 PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 15 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carmody Hills		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		d. STREET ADDRESS 317 73rd St.					
3 NAME OF DECEASED (Type or print) First Middle Last Mattie L Drew		4. DATE OF DEATH Month Day Year June 15 1957					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-17-73	9. AGE (In years last birthday) 84 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Aaron M Evans		14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Frank B Mc Clanahan Carmody Hills Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral Thrombosis 44d.X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic CVD Disease 10 years DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 15, 1957 to June 15, 1957 that I last saw the deceased alive on June 15, 1957, and that death occurred at 5:45 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED William Brainin 6124 Central Ave G/57 PHYSICIAN'S NAME (Type) WM BRAININ Capital Bldg Md							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		6/18/57		Cedar Hill Cemetery		Suitland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Baschewski		ADDRESS Hyattsville, Md		24a. REC'D BY REGISTRAR DATE JUN 19 57		24b. REGISTRAR'S SIGNATURE P. H. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

JUN 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6641

CERTIFICATE OF DEATH

06620

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Pg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md				c. LENGTH OF STAY IN 1b 2 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capital Hgts.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hosp.				d. STREET ADDRESS 616- 59th Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Henry Last Durity				4. DATE OF DEATH Month June Day 27 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 6, 1873	
9. AGE (In years last birthday) yrs 83		IF UNDER 1 YEAR Months 27 Days 27 Hours 19 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plaster		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Beltsville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Abigail Arnold		Address Route 2 Box 646 Springfield, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Broncho genic carcinoma left 16.2 x DUE TO 1 carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1 carcinoma DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/24 , 19 57 , to 6/27 , 19 57 , that I last saw the deceased alive on 6/27 , 19 57 , and that death occurred at 1:20 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE William Durity				ADDRESS (Street, city or town, state) 3503 Chevy St		DATE SIGNED 6/27/57	
PHYSICIAN'S NAME (Type) Dr. Comeau				MT. Rainier Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF July 1, 1957		22c. NAME OF CEMETERY OR CREMATORY Washington National		22d. LOCATION (City, town, or county) (State) Suitland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE H. T. Charney				ADDRESS 517 11th St SE		24a. REC'D BY REGISTRAR DATE JUN 1 57	
				24b. REGISTRAR'S SIGNATURE Reed			

RECEIVED

JUL 2 1957

BUREAU V. S.

6642

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MD. b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGES GEN. HOSP.		d. STREET ADDRESS 7722 EMERSON RD.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First RICHARD Middle O. Last ELAM		4. DATE OF DEATH Month JUNE Day 1 Year 1957	
5 SEX M	6. COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Feb 18, 1919
9. AGE (In years lost, in day) yrs. 38		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boiler operator		10b. KIND OF BUSINESS OR INDUSTRY Power Company	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13 FATHER'S NAME William J. Elam		14 MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) W W 11		16 SOCIAL SECURITY NO	
17 INFORMANT Patricia Elam W Lanham Hills Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Hemorrhagic Pancreatitis 587.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1, 1957 to June 1, 1957 that I last saw the deceased alive on June 1, 1957 and that death occurred at 9:00 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE Frederick E. Musser M.D.		ADDRESS (Street, city or town, state) 24090 Arming St Landover Hills Md.	
DATE SIGNED 6/1/57			
PHYSICIAN'S NAME (Type) FREDERICK MUSSER			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/4/57	22c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery	22d. LOCATION (City, town, or county) (State) Arlington Virginia
23 FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.		ADDRESS	
24a. RECEIVED BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Ch. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 5 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6643

CERTIFICATE OF DEATH

06622

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Prince Georges General Hospital</u>				d. STREET ADDRESS <u>4234-34th Street 1</u>			
3. NAME OF DECEASED (Type or print) <u>William J. Erhart</u> First Middle Last				4. DATE OF DEATH <u>6-13-57</u> Month Day Year			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 1-1879</u>		9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Sheet Metal Worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Sheet metal</u>		11. BIRTHPLACE (State or foreign country) <u>Auburn, N.Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>George Erhart</u>			
14. MOTHER'S MAIDEN NAME <u>Catherine Haha</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>216-22-071A</u>				17. INFORMANT <u>Mrs. Dorothy Carr</u> Address <u>4234-34th Mt. Rainier, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Heart Disease</u> DUE TO (c) <u>3 yrs.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. g. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>52</u> , to <u>JUNE 13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>JUNE 13</u> , 19 <u>57</u> , and that death occurred at <u>3:05 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. C. Hageage</u>				DATE SIGNED <u>6/13/57</u>			
PHYSICIAN'S NAME (Type) <u>C. C. Hageage M.D.</u>				ADDRESS (Street, city or town, state) <u>3308 Perry St., Mt. Rainier, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/15/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley's Funeral Home</u>				ADDRESS <u>Mt. Rainier, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 17 '57</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>			

BUREAU V. S.

JUN 17 1957

RECEIVED

06623

6644

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md. b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chelton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Gen. Hosp.		d. STREET ADDRESS 5308 Taylor Rd.	
3. NAME OF DECEASED (Type or print) Clyde H. Fleck		4. DATE OF DEATH June 4 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-26-17
9. AGE (In years last birthday) 39 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		10b. KIND OF BUSINESS OR INDUSTRY self	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Charles H. Fleck		14. MOTHER'S MAIDEN NAME Virginia Van Meter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO —	
17. INFORMANT Mary E. Fleck		Address Riverdale Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ruptured aortic aneurysm 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic heart disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 minutes 20 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 416X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 20, 1955, to June 4, 1957, that I last saw the deceased alive on June 4, 1957, and that death occurred at 8:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Leonard L. Sontsky		DATE SIGNED 6/4/57	
PHYSICIAN'S NAME (Type) M.D. 4300 Keywood Dr.		44 Rainier, Md.	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/1/57	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Address Frederick Sons Hyattsville Md.		24a. REC'D BY REGISTRAR DATE JUN 10 57	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove verbal papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

UN 10 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6645

CERTIFICATE OF DEATH

Reg. Dist. No.

06624

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Washington, D.C. b. COUNTY 4 in			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.			
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince George's Hospital				d. STREET ADDRESS 4311 13th Street, N.E.			
3. NAME OF DECEASED (Type or print) James William Franks				4. DATE OF DEATH Month June Day 28 Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 9, 1872	
9. AGE (In years last birthday) 85 yrs		IF UNDER 1 YEAR Months 6 Days 1 Hours 57 Min		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Railroad-Illinois	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles F. Franks		14. MOTHER'S MAIDEN NAME Margaret S. Nalls	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Ruby Montgomery-4311 13th St., N.E.		Address	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C. V. A. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic disease DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 6-1-57			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-18 , 19 57 , to 6-28 , 19 57 , that I last saw the deceased alive on 6-28 , 19 57 , and that death occurred at 9:45 M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 3717 - 38th St. Cottage City, Md.			
ACTUAL SIGNATURE George J. Hageage M.D.				DATE SIGNED 6/28/57			
PHYSICIAN'S NAME (Type) George J. Hageage				Cottage City, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/1/1957		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.-2901 14th St., N.W.				ADDRESS Wash. D.C.		24a. RECEIVED BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE W. C. ...							

BUREAU V. S.

1957

RECEIVED

6646

06625

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md.		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Roy Francis Middle Frohlich Last		4. DATE OF DEATH Month June 19 57. Day Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 20, 1912
9. AGE (In years last birthday) 45 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Fireman	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John H. Frohlich		14. MOTHER'S MAIDEN NAME Sadie J. Owens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Lucy Frohlich		Address Same as # 2 (Wife)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>chronic emphysema</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4x0.1</u>			INTERVAL BETWEEN ONSET AND DEATH 1 day 2 yr.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. 1. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5/27</u> , 19 <u>57</u> , to <u>6-1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6-1</u> , 19 <u>57</u> , and that death occurred at <u>3 A.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>George H. Hageage</u> M.D. <u>3717-38th Ave</u> <u>6-1-57</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>George Hageage</u> <u>3717 38th Ave Cottage City, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (specify) Burial	22b. DATE THEREOF 6/4/57	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE P. Gasch's Sons Hyattsville, Maryland.		24. REC'D BY REGISTRAR, DATE JUN 6 57	
24b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 6 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06626

Reg. Dist. No.

6647

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>				d. STREET ADDRESS <u>4630 New Hampshire</u>			
3. NAME OF DECEASED (Type or print) <u>Robert Anthony Gass</u>				4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 8, 1904</u>	
9. AGE (in years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Prisoner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>			
11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>			
13. FATHER'S NAME <u>William Gass</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Lauer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>44-08-38408</u>			
17. INFORMANT <u>Charles E. Gass</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>442X</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>June 12, 1957</u>			
22a. BURIAL CREMATION (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-10-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>		22d. LOCATION (City, town, or county) (State) <u>WASH. D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Hendon</u> ADDRESS <u>3831-GA-Ave. N.W.</u>				24a. REC'D BY REGISTRAR <u>John P. 57</u> DATE <u> </u>			
24b. REGISTRAR'S SIGNATURE <u>W. H. Leach</u>				24c. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

UN 17 1957

RECEIVED

6611

CERTIFICATE OF DEATH

Reg. Dist. No.

230

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park Md		c. LENGTH OF STAY IN 1b 2 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5113 Kenesaw St		d. STREET ADDRESS 5113 Kenesaw St	
3. NAME OF DECEASED (Type or print) First Middle Last BLANCHE B. GOODWIN		4. DATE OF DEATH June 23 1957	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 29, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Washington D.C.
13. FATHER'S NAME Wm E. Clark		14. MOTHER'S MAIDEN NAME Bertha Burke	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Jacqueline R. Petro		Address College Park Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (b), (c), and (d).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) according to autopsy 5 months (c) Adenom. of Metastasis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 1, 1956, to June 24, 1957, that I last saw the deceased alive on June 23, 1957, and that death occurred at 10 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Chester Brady M.D.		DATE SIGNED 3-5-57 (MRE) J.M.	
PHYSICIAN'S NAME (Type) J. Chester Brady		ADDRESS (Street, city or town, state) 35 N Y ave N.W. Washington D. C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/27/57	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington Va.
23. FUNERAL DIRECTOR'S SIGNATURE F Gasche sons Hyattsville Md		24a. REC'D BY REGISTRAR JUN 28 1957	
		24b. REGISTRAR'S SIGNATURE John Smith	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JUN 28 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06628

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>District of Columbia</u> COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale</u> RURAL				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenn Dale Hospital</u>				e. STREET ADDRESS <u>15521 Jay Street, N.E.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN E. GREEN</u>				DATE OF DEATH Month Day Year <u>JUNE 30, 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/29/15</u>	9. AGE (In years last birthday) <u>41</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during kind of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>David Green</u>				14. MOTHER'S MAIDEN NAME <u>Elinabeth Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-12-9155</u>		17. INFORMANT <u>Deceased</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchiogenic Carcinoma left lung</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>162x</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Tuberculosis</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/4/1955</u> to <u>6/30/1957</u> , that I last saw the deceased alive on <u>6/30/1957</u> , and that death occurred at <u>5:35 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>MOE WEISS</u> M.D.				ADDRESS (Street, city or town, state) <u>GLENN DALE HOSPITAL</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>MOE WEISS M.D.</u>				ADDRESS <u>GLENN DALE, MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>6/30/57</u>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Eugene Campbell</u> ADDRESS <u>4339 Hunt Pl. N.E.</u>				24a. REC'D BY REGISTRAR <u>25</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>	

RECEIVED

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6694

CERTIFICATE OF DEATH

06629

Reg. Dist. No.

243

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural (Bowie)</u>		c. LENGTH OF STAY IN 1b <u>67yr</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural (Bowie)</u>	
3. NAME OF DECEASED (Type or print) <u>Ruth</u> First <u>Isabelle</u> Middle <u>Greenfield</u> Last		4. DATE OF DEATH <u>June</u> Month <u>15</u> Day <u>1957</u> Year	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 14, 1890</u> 67 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Gabriel Fletcher</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Randall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-10-5988</u>	
17. INFORMANT <u>Henry Greenfield</u> Address <u>Bowie, md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Gen. Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Supracondylar left leg amputation</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>420.1</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept</u> , 1957, to <u>June</u> , 1957, that I last saw the deceased alive on <u>June 14</u> , 1957, and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>D. Henry A. Wise Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Bowie, md</u>	
PHYSICIAN'S NAME (Type) <u>Henry A. Wise, Jr.</u>		DATE SIGNED <u>Bowie, md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>6-18-1957</u>	<u>Church Cemetery</u>	<u>Bowie Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Rhines & Co.</u> ADDRESS <u>901 3rd St., S. W.</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>Agnes Channing</u>

JUN 18 1957

RECEIVED

JUN 18 1957

BUREAU V

6695

CERTIFICATE OF DEATH

06630

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn Md				c. LENGTH OF STAY IN 1b 8 1/2 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) 4812 71th ave				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Rufus Last Griffiths Sr				4. DATE OF DEATH Month June Day 10 Year 1957			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 25, 1871	9. AGE (In years last birthday) 85 years	IF UNDER 1 YEAR Months 8 Days 10 Hours 19 Min	IF UNDER 24 HRS Hours 19 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Real Estate Broker Self			10b. KIND OF BUSINESS OR INDUSTRY Self			11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U S A			13. FATHER'S NAME William G. Griffiths				
14. MOTHER'S MAIDEN NAME Emma Malloy			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				
16. SOCIAL SECURITY NO. none			17. INFORMANT Helen G. Griffiths Woodlawn, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) 10 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Jan 19 55 , to June 19 57 , that I last saw the deceased alive on 10 Jun 19 57 , and that death occurred at 9:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas G. Maloney M.D.				ADDRESS (Street, city or town, state) 4814-71st Ave. Landover Hills Md			
DATE SIGNED June 14 1957				22a. REGISTRATION BY REGISTRAR John G. Maloney			
22b. REGISTRAR'S SIGNATURE THOMAS G. MALONEY				22c. NAME OF CEMETERY OR CREMATORY Uniondale Cemetery			
22d. LOCATION (City, town, or county) Pittsburg, Pa.				22e. (State) Pa.			
23. FUNERAL DIRECTOR'S SIGNATURE F. GASCH'S SONS				ADDRESS Hyattsville, Md.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for use in burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 14 1957

RECEIVED

6648

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 14 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Harry John Hammill (Hammill)				4. DATE OF DEATH June 30 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-19-94	
9. AGE (In years last birthday) 63 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Job Printing		11. BIRTHPLACE (State or foreign country) Chicago, Ill.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME John Hammill			
14. MOTHER'S MAIDEN NAME Mary Pope				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) Yes WW1			
16. SOCIAL SECURITY NO. 578-01-1866				17. INFORMANT Lula M. Hammill, 5420--55th Place East Riverdale, Md.			
18. CAUSE OF DEATH [Enter only one cause per line (a), (b) and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident						2 wks.	
DUE TO 443X							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						(b) Hypertensive cardiovascular disease	
DUE TO						(c) 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
331X							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 2/16/56 , 19 56 , to 6/30 , 19 57 , that I last saw the deceased alive on 6/30 , 19 57 , and that death occurred at 8:15 P M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE Julius Kauffman M.D. 5102 Annapolis Rd. Bethesda, Md.				6/7/57			
PHYSICIAN'S NAME (Type) Dr. Julius Kauffman							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/3/1957		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers ADDRESS 5301 Leeland Prince George				24a. REC'D BY REGISTRAR DATE JUL 3 '57		24b. REGISTRAR'S SIGNATURE Alfred	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

1957

DEAL

RECEIVED
JUN 14 1957
BUREAU V. B.

6649 *lie 6-17-57 et*
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

Reg. Dist. No.

06633

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) N. BRENTWOOD				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) N. BRENTWOOD			
c. LENGTH OF STAY IN 1b 50 YRS.							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4510 Church STREET				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) FRANK LEROY HOLMES				4. DATE OF DEATH 6-8-1957			
5. SEX M		6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-16-1873	
9. AGE (In years last birthday) 83 84 yrs		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COOK		10b. KIND OF BUSINESS OR INDUSTRY RESTAURANT		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 217-03-6592		17. INFORMANT Lillian L. Moore Address 4510 Church St. N. Brentwood, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocarditis and Endocarditis DUE TO (c) 1953						INTERVAL BETWEEN ONSET AND DEATH JAN. 1957	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Oct. 15, 1953, to 6-8-1957 that I last saw the deceased alive on 6-7-1957 , and that death occurred at 9:14 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE H. H. Spiller				ADDRESS (Street, city or town, state) 4506 R. I. Ave. BRENTWOOD, Md. DATE SIGNED 11/4/57			
PHYSICIAN'S NAME (Type) W. W. Spiller M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) 6-11-57		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Carver Men.		22d. LOCATION (City, town, or county) (State) Prince Geo. Co. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington ADDRESS 467 N 3rd St. N.W.				24a. REC'D BY REGISTRAR 11/2/57		24b. REGISTRAR'S SIGNATURE Carl...	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 12 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06634

Reg. Dist. No.

245

6650

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN 1b 1 Day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorila Hospital				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lothian d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Darth Middle Leon Last Holt			4. DATE OF DEATH Month June 26, Year 1957				
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/15/1912	9. AGE (last day) 45 yrs.	10. IF UNDER 1 YEAR Months _____ Days _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY U.S. Naval Yard		11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Eugene Holt				
14. MOTHER'S MAIDEN NAME Sarah Harvey			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO				
16. SOCIAL SECURITY NO. _____			17. INFORMANT Address Hospital Records				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO (b) Cerebral Concussion & Fracture-Dislocation of (c) Seventh Cervical Vertebra Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) which collided with a Jack-knifed Tractor, Passenger in an Auto.		20c. TIME OF INJURY Month, Day, Year 5:05 a.m. 6/25/ 57					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) Beltsville (County) Prince Georges Md. (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John T. Maloney</i> EXAMINER'S NAME (Type) John T. Maloney MD.			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) 6-30		22b. DATE THEREOF 6-30		22c. NAME OF CEMETERY OR CREMATORY St. Ann's			
22d. LOCATION (City, town, or county) Lothian Md (State)		23. FUNERAL DIRECTOR'S SIGNATURE <i>William J. Reese</i> ADDRESS <i>11 Anna, Md.</i>					
24a. REC'D BY REGISTRAR <i>James L. Reese</i>		24b. REGISTRAR'S SIGNATURE <i>James L. Reese</i>					

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

JUN 28 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6617

CERTIFICATE OF DEATH

06635

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt Rainier			c. LENGTH OF STAY IN 1b 3 Yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt Rainier	
d. NAME OF HOSPITAL (If not in hospital, give street address) 4523 32nd Street				d. STREET ADDRESS 4523 32nd Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Helen Middle Nae Last Jett				4. DATE OF DEATH Month June Day 17 Year 1957			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1871		9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME David Gibson				14. MOTHER'S MAIDEN NAME Sarah Rhodier			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Milton G. Jett same as No 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DEHYDRATION 159x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SENILE ARTERIOSCLEROSIS DUE TO (c) PROBABLE G.I. MALIGNANCY						INTERVAL BETWEEN ONSET AND DEATH 2 days 2 year 7	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. n. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan , 19 56 , to June , 19 57 , that I last saw the deceased alive on June 15 , 19 57 , and that death occurred at 9:45 P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Benjamin S. Miller M.D.				ADDRESS (Street, city or town, state) 3824-34th St. Hyattsville Md		DATE SIGNED June 19 1957	
PHYSICIAN'S NAME (Type) BENJAMIN S. MILLER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/20/57		22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Rasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE JUN 24 1957	
				24b. REGISTRAR'S SIGNATURE James Shoups			

RECEIVED
JUN 24 1957
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar to burial, cremation, or removal, and in any event within 72 hours after death.

6651

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06636

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>3 weeks</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kent Village</u>		d. STREET ADDRESS <u>7329 Forest Rd</u>	
d. NAME OF HOSPITAL (If not in hospital, give place of death) <u>SACORDA Rest Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Barth</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>June</u> Day <u>18</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 9, 1871</u>
9. AGE (In years last birthday) <u>87</u> yrs		IF UNDER 1 YEAR: Months <u>8</u> Days <u>8</u> Hours <u>8</u> Min <u>8</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Phillip Barth</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Elwood D. Jones</u>		Address <u>Kent Village, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>552X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> (c) <u>General Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>7 years</u> <u>7 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>no</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/1</u> , 1957, to <u>6/18</u> , 1957, that I last saw the deceased alive on <u>6/17</u> , 1957, and that death occurred at <u>2:34</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>WORMAN DONAT BMEAU</u> M.D.		ADDRESS (Street, city or town, state) <u>3503 Penny St</u> DATE SIGNED <u>6/18/57</u>	
PHYSICIAN'S NAME (Type) <u>WORMAN DONAT BMEAU</u>		M.T. <u>RAINIER MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/20/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Queens New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Rasch's Sons Hyattsville, Maryland.</u>		ADDRESS <u>Hyattsville, Maryland.</u>	
24a. REC'D BY REGISTRAR <u>DATE JUN 20 57</u>		24b. REGISTRAR'S SIGNATURE <u>W. Rasch</u>	

RECEIVED
JUN 20 1957
TEAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06637

6697

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY Prince Georges' MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Pr. Geo's	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Cedarville		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cedarville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Cedarville Road		STREET ADDRESS (If rural, give location) Cedarville Road	
3. NAME OF DECEASED (Type or Print)	(First) William	(Middle) ---	(Last) Jowett
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 3, 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	9. AGE last birthday 75 yrs.
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Jowett		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. -----	
17. INFORMANT AND ADDRESS Mrs. Alta Jowett P.O. Brandywine, Md.)			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH Years
(a) Acute Myocarditis, Congestive			
(b) Arterio Sclerosis			
(c) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from May 45 , 19 45 , to June 3 , 19 47 , that I last saw the deceased alive on 6-3 , 19 47 , and that death occurred at 3:45 P. m. from the causes and on the date stated above.			
SIGNATURE W. C. J. Jowett		DATE SIGNED MD. 6-5-47	
23. BURIAL CREMATION REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
Burial		St. Thomas Cemetery	
DATE REC'D BY LOCAL REG. JUN 11 1947		LOCATION (City, town, or county) (State) Croom, Md.	
REGISTRAR'S SIGNATURE W. C. J. Jowett		24. FUNERAL DIRECTOR ADDRESS Ritchie Bros. Upper Marlboro, Md.	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 12 1967

BUREAU V. S.

6652

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 2 Hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2 Colmar Manor			
f. STREET ADDRESS 3612 39th Ave				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Baby Girl Middle Judd Last Judd				4. DATE OF DEATH Month 6-19 Day 19 Year 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-19-57	
9. AGE (In years lost birthday) yrs.		IF UNDER 1 YEAR Months 4 Days 7		IF UNDER 24 HRS Hours 50 Min 50			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Carroll Judd				14. MOTHER'S MAIDEN NAME Edna Humphries			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT mother Address as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Prenatal injury of fetus							
X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 6/19, 1957 to 6/19, 1957 that I last saw the deceased alive on 6/19, 1957 and that death occurred at 6:00 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE George Hageage				DATE SIGNED Colmar Manor, 6/20/57			
PHYSICIAN'S NAME (Type) George Hageage, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF July 1957		22c. NAME OF CEMETERY OR CREMATORY Prince Georges Sanitary Cemetery		22d. LOCATION (City, town, or county) (State) Cheverly Md	
23. FUNERAL DIRECTOR'S SIGNATURE Henry R. Camp				24a. REC'D BY REGISTRAR John		24b. REGISTRAR'S SIGNATURE John	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for use as the burial-transit permit.

BUREAU V. S.

JUL 22 1957

RECEIVED

6613

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Filed 7-6-57

CERTIFICATE OF DEATH

06638

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Prince George Co MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE -- b. COUNTY --			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Home				d. STREET ADDRESS 3511 Rittenhouse St., NW			
3 NAME OF DECEASED (Type or print) (Helen) Nellie Veronica Keefe				4. DATE OF DEATH Month June Day 23 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 23 - 1879	9. AGE (In years last birthday) 78 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Wash D C		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Patrick Keefe				14. MOTHER'S MAIDEN NAME Annie Keefe O'Connor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular hemorrhage 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic heart disease DUE TO (c) 15 months						INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 11X						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 20, 1957 to June 23, 1957 , that I last saw the deceased alive on June 23, 1957 , and that death occurred at 11:00 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas F Collins				ADDRESS (Street, city or town, state) 322 H St. NE			
DATE SIGNED 6-23-57				DATE SIGNED			
PHYSICIAN'S NAME (Type) THOMAS F COLLINS M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/25/57		22c. NAME OF CEMETERY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE James J. ...				ADDRESS 317 Penna. Ave., SE DC3		24b. REGISTRAR'S SIGNATURE ...	
				24a. REC'D BY REGISTRAR JUN 25 1957			

BUREAU V. S.

JUN 25 1957

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06639

6698

CERTIFICATE OF DEATH

Reg. Dist. No.

230

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE --- b. COUNTY ---			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - College Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Saint Francis Nursing Home				d. STREET ADDRESS 4521 Windom Place, N.W.			
3. NAME OF DECEASED (Type or print) First Middle Last Barbara Margaret Heller				4. DATE OF DEATH Month Day Year June 28 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 26 1868	
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) District of Columbia				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Jacob Inc. Klier				14. MOTHER'S MAIDEN NAME Margaretta Englehart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none			
17. INFORMANT Address records at nursing home							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 6/25, 1957, to 6/28, 1957, that I last saw the deceased alive on 6/27/57, 19, and that death occurred at 2:50 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE A.W. Smith				ADDRESS (Street, city or town, state) 4601 16th St NW			
PHYSICIAN'S NAME (Type) A.W. SMITH				DATE SIGNED 6/28/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/1/1957		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. - 2901 14th St., N.W.				ADDRESS Wash. D.C.		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	

BUREAU V. B.

JUL 1 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06640

6653

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Chevy Chase</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5115 Fairglen Lane</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John Keepler</u> First Middle Last				4. DATE OF DEATH <u>June 14 1957</u> Month Day Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/15/1865</u>	9. AGE (in years last birthday) <u>91</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wholesale merchant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>self</u>	11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Keepler</u>				14. MOTHER'S MAIDEN NAME <u>Theresa Keppler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Mrs. L. E. Spiegler-3417 Fessenden St. N.W.</u>			
17. INFORMANT <u>Wash. D. C.</u>				Address <u>Wash. D. C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA TOSIS</u> <u>1941</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA OF AURICLE</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>3 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>4/2</u> , 19 <u>57</u> , to <u>6/14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/10</u> , 19 <u>57</u> , and that death occurred at <u>4:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John Kenoe</u> M.D. <u>CHEVERLY MD</u>				DATE SIGNED <u>6/14/57</u>			
PHYSICIAN'S NAME (Type) <u>JOHN KENOE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/17/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co. Washington, D. C.</u>				24a. REC'D BY REGISTRAR <u>JUN 17 57</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Hines</u>	

BUREAU V. S.

JUN 17 1957

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6614

CERTIFICATE OF DEATH

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington, D. C. 472 b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C. 472			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hyattsville Nursing Home				d. STREET ADDRESS 2206 Lawrence Street, N. E.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Marie Emma King				4. DATE OF DEATH Month Day Year June 30, 1957 19			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 14, 1868	9. AGE (In years last birthday) yrs. 88	IF UNDER 1 YEAR Months Days 8 16	IF UNDER 24 HRS Hours Min. 6	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME George Henderson				14. MOTHER'S MAIDEN NAME Fannie B. Anderson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Thomas H. King-3600 Raymond St., Chevy Chase, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Rupture 4415 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility						INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 15, 1955 to June 30, 1957 , that I last saw the deceased alive on June 30, 1957 , and that death occurred at 11:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Walden B. King M.D. 3500 R. 1st St. N.W. Wash. D.C. PHYSICIAN'S NAME (Type) Walden B. King							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/1/57		22c. NAME OF CEMETERY OR CREMATORY Congressional		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR 2 1957		24b. REGISTRAR'S SIGNATURE James Secor	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 2 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06642

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Hyattsville</u>				c. LENGTH OF STAY IN 1b <u>Brentwood</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3203- Madison Street</u>				d. STREET ADDRESS <u>4003- Utah Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>Mary Agnes Langford</u>				4. DATE OF DEATH Month <u>June</u> Day <u>7th</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-7-1884</u>	9. AGE (in years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>11</u> Hours <u>45</u> Min	IF UNDER 24 HRS Hours <u>45</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Iron home</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Gorman</u>				14. MOTHER'S MAIDEN NAME <u>Dora Roth</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-016260</u>		17. INFORMANT <u>Dorothy Bischoff</u> 3 Address <u>3-Madison W. Hyattsville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease with failure</u> 400.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Diverticulitis with sinus</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>57.0</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. g. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 20</u> , 1957, to <u>June 7</u> , 1957, that I last saw the deceased alive on <u>June 7</u> , 1957, and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Earl W. Graeff</u> M.D.				ADDRESS (Street, city or town, state) <u>2716 Kirkwood Place W. Hyattsville, Md.</u>			
PHYSICIAN'S NAME (Type) <u>EARL W. GRAEFF</u>				DATE SIGNED <u>June 11 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/10/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Malley's Funeral Home</u>				ADDRESS <u>W. Hyattsville, Md.</u>			
24a. REC'D BY REGISTRAR <u>June 11 1957</u>		24b. REGISTRAR'S SIGNATURE <u>James A. ...</u>					

245

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RECEIVED
JUN 11 1957
BUREAU V. S.

6699

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE D. C. b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		d. STREET ADDRESS 67 Decatur St., N. E.	
3. NAME OF DECEASED (Type or print) First Charles Middle — Last Lee		4. DATE OF DEATH Month 6 Day 11 Year 19 57	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/13/10
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY United Cleaners & Dyers	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Lee		14. MOTHER'S MAIDEN NAME Gertrude Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 568-09-4565	
17. INFORMANT Decedent		Address —	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of liver, with ascites DUE TO 5 7/10 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis, adenocarcinoma of the rectum, and diabetes mellitus			INTERVAL BETWEEN ONSET AND DEATH 3 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/6 19 50, to 6/11 19 57, that I last saw the deceased alive on 6/11 19 57, and that death occurred at 11:00AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Moe Weiss		ADDRESS (Street, city or town, state) Glenn Dale Hospital DATE SIGNED 6/11/57	
PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		Glenn Dale, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6-11-57	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington 467 N. St. N. W.		24a. REC'D BY REGISTRAR DATE JUN 13 57	
24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JUN 13 1957
BUREAU V. S.

6654

CERTIFICATE OF DEATH

06644

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE MD b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FAIRMONT HEIGHTS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGES GEN. HOSP.		d. STREET ADDRESS 722 - 60th. PL.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SHEILA Middle LEE Last		4. DATE OF DEATH Month JUNE Day 16 Year 1957	
5. SEX FEM.	6. COLOR OR RACE COL.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/1/54
9. AGE (In years last birthday) 3 yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Burgess Lee		14. MOTHER'S MAIDEN NAME Gladys Deal	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Trauma G.D. human bite DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sept. E. coli virus DUE TO (c) Bleeding embolus (abdominal)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/13, 1957 , to 6/16, 1957 , that I last saw the deceased alive on 6/16, 1957 , and that death occurred at 3:58 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Max W. Hargberg		ADDRESS (Street, city or town, state) DATE SIGNED	
M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 6-19-57	22c. NAME OF CEMETERY OR CREMATORY MT Olivet Cem.	22d. LOCATION (City, town, or county) (State) Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE F.B. Washington & Sons		ADDRESS 467 N St NW	
24a. REC'D BY REGISTRAR W. H. Hargberg		DATE JUN 19 57	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 19 1957

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

to: 20 July 217 7
6655

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06645

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ieland Memorial Hospital				d. STREET ADDRESS 2705 Nicholson Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Jerry Joseph Gunter Lewis				4. DATE OF DEATH Month Day Year June 16 19 57					
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 7, 1957			
9. AGE (in years last birthday) 2 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 2		IF UNDER 24 HRS. Hours Min. 2					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington, D.C.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME James W. Lewis				14. MOTHER'S MAIDEN NAME Ursula Honoy					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Father; same address.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Conditions, if any, which gave rise to immediate cause (b) Aspiration of stomach contents (c) Aspiration of stomach contents DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None								INTERVAL BETWEEN ONSET AND DEATH None	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Same as I B					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 6-16-57 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hyattsville 1. Geo Md.			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 16, 1957					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/19/57		22c. NAME OF CEMETERY OR CREMATORIUM Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR June 16 1957			
						24b. REGISTRAR'S SIGNATURE James L. Lacey			

9VVVVVVVVXVV

RECEIVED

JUN 20 1957

STANDARD

6656

CERTIFICATE OF DEATH

06646

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE <u>Md</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale Md.</u>				c. LENGTH OF STAY IN 1b <u>12 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Leland Memorial</u>				e. STREET ADDRESS <u>8702-Baltmore Ave</u>			
3. NAME OF DECEASED (Type or print) <u>WILBUR</u> First <u>S</u> Middle <u>Liggett</u> Last				4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 18, 1904</u>	9. AGE (In years last birthday) <u>53</u> yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Keeper</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>W. Va.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		
13. FATHER'S NAME <u>WARDEN</u>				14. MOTHER'S MAIDEN NAME <u>Lee</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>WIFE</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bleeding gastric and Esophageal Varices not known</u> DUE TO (c) <u>Cirrhosis, liver</u>						INTERVAL BETWEEN ONSET AND DEATH <u>13 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Alcoholism</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>12 June, 1957</u> , to <u>23 June, 1957</u> , that I last saw the deceased alive on <u>23 June, 1957</u> , and that death occurred at <u>6:15 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Marion L. Kolkin</u> M.D.				ADDRESS (Street, city or town, state) <u>2025 Eye Street, N.W., D.C.</u>			
PHYSICIAN'S NAME (Type) <u>MARION L. KOLKIN</u>				DATE SIGNED <u>JUN 27 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 26, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>				24a. REC'D BY REGISTRAR <u>JAMES E. LEWIS</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6700

CERTIFICATE OF DEATH

06647

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Bowie</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>St.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Avondale</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Avondale</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2114 Queens Chapel Road</i>		d. STREET ADDRESS <i>2114 Queens Chapel Road</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Theresa Cecilia Littleton</i>		4. DATE OF DEATH Month Day Year <i>June 3, 1957</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/8/81</i>
9. AGE (In years last birthday) <i>75</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Pennsylvania</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Charles Bauer</i>		14. MOTHER'S MAIDEN NAME <i>Laura V. Coom</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Laura V. Schiesser</i>		Address <i>Oreland, Pa.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatosis</i> <i>15 4 X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Adeno carcinoma, rectum</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>4 months</i> <i>14 months</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Sept. 16</i> , 19 <i>47</i> , to <i>June 3</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>June 3</i> , 19 <i>57</i> , and that death occurred at <i>7:25</i> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>Frank R. Shea</i> M.D. <i>4100-22nd St. W.E. WADDC 4/3/57</i>			
ACTUAL SIGNATURE <i>FRANK R. SHEA, M.D.</i>			
PHYSICIAN'S NAME (Type) <i>FRANK R. SHEA, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	22b. DATE THEREOF <i>6/6/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Suitland, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co, 2901 14th St. N.W.</i>		24. REC'D BY REGISTRAR <i>1957</i> REGISTRAR'S SIGNATURE	

BUREAU V. S.

JUN 6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6657

CERTIFICATE OF DEATH

06648

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg, Md.			c. LENGTH OF STAY IN 1b 4 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 23 Bladensburg, Md.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5803 Annapolis Road				d. STREET ADDRESS 5803 Annapolis Road,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gordon Middle Louk Last				4. DATE OF DEATH June 15, 19 57.			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 22, 1897	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Broker				10b. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Enoch M. Louk				14. MOTHER'S MAIDEN NAME Hannah Ware			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 577-07-2243		17. INFORMANT Jane Lenore Louk Address Bladensburg, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Antibiotic PT disease DUE TO (c) 2 yr ago INTERVAL BETWEEN ONSET AND DEATH 5 min 2 yr							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prev. coronary occlusion 2 yr ago 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 3404 Cheverly Ave Cheverly Md				20g. (County) Prince Georges		20h. (State) Md.	
21. I certify that I attended the deceased from Jan 1957 , to June 15, 1957 , that I last saw the deceased alive on June 15, 1957 , and that death occurred at 11:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3404 Cheverly Ave Cheverly Md DATE SIGNED 6/18/57							
ACTUAL SIGNATURE John Kehoe M.D.				3404 Cheverly Ave Cheverly Md			
PHYSICIAN'S NAME (Type) John Kehoe				3404 Cheverly Ave Cheverly Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/18/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				24a. REC'D BY REGISTRAR JUN 20 1957 24b. REGISTRAR'S SIGNATURE H. A. Daniel			

1341 U.S.

JUN 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6658

CERTIFICATE OF DEATH

06649

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 9 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. STREET ADDRESS 6542 Buchannon St.			
3. NAME OF DECEASED (Type or print) First Middle Last Eloise Elizabeth Luckett				4. DATE OF DEATH Month Day Year June 15 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 23 June 1891	9. AGE (In years last birthday) 65 yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife			10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Montgomery Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George Mulicon				14. MOTHER'S MAIDEN NAME UNKNOWN.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO None		17. INFORMANT Evelyn E. Beach,		Address 5108 Chittenden St Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Acute Cholecystitis DUE TO Acute saliv. & ARD (c) —							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 585X							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 6/6 , 19 57 , to 6/15 , 19 57 that I last saw the deceased alive on 6/15 , 19 57 , and that death occurred at 12:55A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Norman Donat Comeau M.D.				ADDRESS (Street, city or town, state) 3503 Penn/31 DATE SIGNED 6/15/57			
PHYSICIAN'S NAME (Type) NORMAN DONAT COMEAU				MT RAINIER MD			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		6/19/57		FT. LINCOLN		Pr. Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers				ADDRESS 5801 Cleveland			
24a. DEC'D BY REGISTRAR JUN 18 '57				24b. REGISTRAR'S SIGNATURE DeLoach			

BUREAU V. B.

JUN 18 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

6701

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE D. C. b. COUNTY — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1315 Clifton St., N. W., Apt., 105 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First French Middle — Last Marshall		4. DATE OF DEATH Month 6 Day 19 Year 1957	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/12/1907
9. AGE (In years last birthday) 50 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Window Washer	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Solomon Marshall		14. MOTHER'S MAIDEN NAME Bessie Pinket	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Supportive pneumonitis of right lung with multiple abscesses DUE TO (b) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) — DUE TO (c) —			INTERVAL BETWEEN ONSET AND DEATH 1 month
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 21X			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6/17 , 19 57 , to 6/19 , 19 57 , that I last saw the deceased alive on 6/19/57 , and that death occurred at 5:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Glenn Dale Hospital 6/19/57			
ACTUAL SIGNATURE Moe Weiss		M.D. Glenn Dale Hospital	
PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		Glenn Dale, Md.	
22a. BURIAL <input type="checkbox"/> CREMATON, REMOVED (Specify)	22b. DATE THEREOF 6/23/57	22c. NAME OF CEMETERY OR CREMATORY Church Cemetery	22d. LOCATION (City, town, or county) (State) Mt. Pleasant, Va.
23. FUNERAL DIRECTOR'S SIGNATURE John T. Kinner & Co.		ADDRESS 901 3rd St. S.W.	24a. REC'D BY REGISTRAR DATE JUN 24 57
		24b. REGISTRAR'S SIGNATURE Arthur	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be filed with the registrar. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 24 1957

RECEIVED

6659

CERTIFICATE OF DEATH

Reg. Dist. No.

06651234

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>500 9th St</u>		d. STREET ADDRESS <u>500 9th St</u>	
3. NAME OF DECEASED (Type or print) <u>GEORGE</u> First <u>MATTHEWS</u> Middle <u>LAST</u> Last		4. DATE OF DEATH <u>June</u> Month <u>17</u> Day <u>1957</u> Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 14 1893</u>
9. AGE (In years last birthday) <u>64</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Track Torman on B&O Railroad</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>THOMAS MATTHEWS</u>		14. MOTHER'S MAIDEN NAME <u>HATTIE DAVIS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>705-09-7303</u>	
17. INFORMANT <u>PEARL MATTHEWS</u> Address <u>500-9th St. LAUREL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction - 451X</u> DUE TO <u>451X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction</u> DUE TO <u>Myocardial infarction</u> (c) <u>Myocardial infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour: a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/17</u> , 19 <u>57</u> , to <u>6-17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 17, 1957</u> , and that death occurred at <u>4:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W B Steward</u> M.D. <u>314</u>		ADDRESS (Street, city or town, state) <u>314 Compton Ave Laurel</u> DATE SIGNED <u>June 24 1957</u>	
PHYSICIAN'S NAME (Type) <u>W B Steward</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>June 20 1957</u>	<u>Murkert Cemetery</u>	<u>Laurel</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ridgely Kelly</u> ADDRESS <u>401 Washington St Laurel MD</u>		24a. REC'D BY REGISTRAR <u>June 24 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Theresa Brashers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 24 1957

RECEIVED

6660

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06652

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Dist. of Col. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
c. LENGTH OF STAY IN 1b D.O.A.				d. STREET ADDRESS 1020 Buchanan Street			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Samuel Last McBreen				4. DATE OF DEATH Month June Day 9 Year 1957			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 10, 1886	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 71 Days 71 Hours 71 Min.		IF UNDER 24 HRS. Months 71 Days 71 Hours 71 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping clerk				10b. KIND OF BUSINESS OR INDUSTRY Printing		11. BIRTHPLACE (State or foreign country) Ireland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Mc Breen				14. MOTHER'S MAIDEN NAME Mary Ann Neale			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W. 1				16. SOCIAL SECURITY NO. Kathleen M. McBreen; same address			
17. INFORMANT Kathleen M. McBreen; same address				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Cardiovascular renal disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 434.1							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 9, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/12/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE A. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR June 13 '57	
				24b. REGISTRAR'S SIGNATURE Arthur			

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

1957

RECEIVED

6661

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Prince George MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	
c. LENGTH OF STAY IN 1b 8 hrs		d. STREET ADDRESS 3404 Laurel Ave	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle Girl Last McCauley		4. DATE OF DEATH Month June Day 5 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 June 1957
9. AGE (In years last birthday) yrs. 1		IF UNDER 1 YEAR IF UNDER 24 HRS Months 1 Days 1 Hours 1 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Cheverly, Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Frank McCauley		14. MOTHER'S MAIDEN NAME Margaret O'Donnell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) PREMATURITY - (27 WKS) DUE TO SEPARATION OF PLACENTA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) SEPARATION OF PLACENTA DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a m p m 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/4 , 19 57 , to 6/5 , 19 57 , that I last saw the deceased alive on 6/5 , 19 57 , and that death occurred at 6:00A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) CHEVERLY, MD DATE SIGNED 6/5/57 ACTUAL John Kehoe M.D. CHEVERLY, MD PHYSICIAN'S NAME (Type) JOHN KEHOE CHEVERLY, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		6/5/57	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Mt. Airy		Washington, DC	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
Malley's Funeral Home		DATE JUN 6 '57	
ADDRESS Mt. Rainier, Md.		24b. REGISTRAR'S SIGNATURE Alfred	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 6 1957

RECEIVED

6662

CERTIFICATE OF DEATH

06654

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 9 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Dudley Manning McClure				4. DATE OF DEATH Month Day Year June 24 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-12-52	
9. AGE (In years last birthday) 5 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Edward Joseph Mc Clure				14. MOTHER'S MAIDEN NAME Mary L Mc Gaha			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) --				16. SOCIAL SECURITY NO --		17. INFORMANT Address Hospital records Cheverly, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) multiple Perforations DUE TO perforation of jejunal suture line. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) Bladensburg		(County) (State)	
21. I certify that I attended the deceased from 6/24 , 19 57 , to 6/24 , 19 57 , that I last saw the deceased alive on 6/24 , 19 57 , and that death occurred at 11:30P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5304 Annapolis Rd DATE SIGNED 6/25							
ACTUAL SIGNATURE Dayton O Watkins M.D.				PHYSICIAN'S NAME (Type) DAYTON O. Watkins			
22a. BURIAL, CREMATION, REMOVAL, (Specify) Burial				22b. DATE THEREOF 6/27/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	
				22d. LOCATION (City, town, or county) Colmar Manor, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland.		24a. REC'D BY REGISTRAR DATE JUN 28	
				24b. REGISTRAR'S SIGNATURE D. K. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JUN 28 1957
BUREAU V. S.

6663

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 5 Hours		2. USUAL RESIDENCE (Where deceased lived) a. STATE D. C. b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print) Judge First Middle Last McCoy		4. DATE OF DEATH Month Day Year June 3 19 57	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-6-02	
9. AGE (In years last birthday) 55 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Mason		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Mason		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William McCoy		14. MOTHER'S MAIDEN NAME Mary Liza Bowler		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT John McCoy 1461 Fla. Ave. N.W. Wash. D.C.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 22X DUE TO Ruptured syphilitic aneurysm of the ascending and arch of the aorta. Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) of the ascending and arch of the aorta. (c) the aorta.		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 6/3, 1957 to 6/3, 1957 that I last saw the deceased alive on 6/3, 1957 , and that death occurred at 4:15 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
21. I certify that I attended the deceased from 6/3, 1957 to 6/3, 1957 that I last saw the deceased alive on 6/3, 1957 , and that death occurred at 4:15 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED			
ACTUAL SIGNATURE Max M. Herzberg		M. D.		PHYSICIAN'S NAME (Type) Dr. Max Herzberg			
22a. BURIAL, CREMATION, --REMOVAL (Specify) 6/8/57		22b. DATE THEREOF 6/8/57		22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Harry S. Washington		ADDRESS 447 N. St. N.W.		24a. REC'D BY REGISTRAR DATE JUN 10 '57		24b. REGISTRAR'S SIGNATURE Overland	

VS A15 (4)
ISM 9/55

BUREAU V. S.

JUN 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6664

CERTIFICATE OF DEATH

06656

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's Hospital		d. STREET ADDRESS 1113 Oakdale Drive	
3. NAME OF DECEASED (Type or print) First Middle Last May Irwin Mc Dowell		4. DATE OF DEATH Month Day Year June 2, 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 9, 1881
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) New York
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no	
16. SOCIAL SECURITY NO. no		17. INFORMANT Francis J. Mc Dowell Address Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Tamponade due to DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) rupture of ant. wall of left ventricle. DUE TO (c) Coronary Arteriosclerosis.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6-2, 19 57, to 6-4, 19 57 that I last saw the deceased alive on 6-3, 19 57, and that death occurred at 1:20 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE A Deitz		ADDRESS (Street, city or town, state) Hyattsville Md DATE SIGNED 6/2/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/4/57	22c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	22d. LOCATION (City, town or county) (State) Long Island City New York
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland.		24a. REC'D BY REGISTRAR DATE JUN 5 '57	24b. REGISTRAR'S SIGNATURE Deitz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove correct papers. Pages 1 and 2 should be filed with the registrar to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 5 1957

RECEIVED

6702
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Sears - Merchant		4. DATE OF DEATH Month Day Year 6 18 19 57	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/30/10
9. AGE (in years last birthday) 46 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min 6 yrs., 2 mos., 3 days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Jacobs Transfer Co., S. Carolina	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Golden D. Merchant		14. MOTHER'S MAIDEN NAME Annie McFadden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No -		16. SOCIAL SECURITY NO. 578-05-7933	
17. INFORMANT Decedent		Address -	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH 6 yrs., 6 mos., 3 days			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/13 , 19 51 , to 6/18 , 19 57 , that I last saw the deceased alive on 6/18 , 19 57 , and that death occurred at 6:50 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Moe Weiss		ADDRESS (Street, city or town, state) Glenn Dale Hospital	
PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		DATE SIGNED 6/18/57	
22a. NAME OF CEMETERY OR CREMATORY Carver Memorial Park		22b. LOCATION (City, town, or county) (State) Prince Georges Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE B. M. Horton		24a. REC'D BY REGISTRAR 2157	
24b. REGISTRAR'S SIGNATURE 2157			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 21 1957

RECEIVED

may be retained by the hospital or attending physician.
THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06658

6703

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>702 16th St. N.E. District of Columbia</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suitland Nursing Home</u>				d. STREET ADDRESS <u>702 16th St. N.E.</u>			
3 NAME OF DECEASED (Type or print) First <u>Rattie</u> Middle <u>M.</u> Last <u>Miller</u>				4. DATE OF DEATH Month <u>June</u> Day <u>18</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 8, 1877</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11 BIRTHPLACE (State or foreign country) <u>T.B. Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. of A.</u>							
13. FATHER'S NAME <u>Elye Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Myron Adams</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Myrtle Ward, Accokeek, Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart Failure</u>							<u>1 hour</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u>							<u>4 years +</u>
(c) <u>Arteriosclerosis Generalized</u>							<u>10 years +</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.0</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> or work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>							
21. I certify that I attended the deceased from <u>April 24, 1957</u> , to <u>June 18, 1957</u> , that I last saw the deceased alive on <u>June 18, 1957</u> , and that death occurred at <u>7:15</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walcutt W. Gibson</u>				ADDRESS (Street, city or town, state) <u>2412 Minnesota Avenue, S.E.</u>			
DATE SIGNED <u>6/18/57</u>							
PHYSICIAN'S NAME (Type) <u>Walcutt W. GIBSON</u>				Washington 20, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/22/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem</u>		22d. LOCATION (City, town, or county) (State) <u>SUITLAND - Prince Georges Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co - 517-11th St SE</u>				ADDRESS <u>Washington</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u> </u>	
24b. REGISTRAR'S SIGNATURE <u> </u>							

RECEIVED

Washington D.C.
 212 Minnesota Avenue, S.E.
 June 18, 1957
 BUREAU V. S.

Atterbury's Generalist
 Atterbury's Heart Disease
 Heart Failure
 1 hour
 1 hour
 1 hour

Myrtle Ward, Asokor, Va.
 Myron Adams
 T.B. Maryland
 N. 2. 4. A.

Miller
 June 18, 57
 85
 702 10th St. S.E.
 Washington

1957 to 1958

Walter M. (1820)
 212 Minnesota Avenue
 June 18, 57

No
 Elye Thompson
 Home
 Famous White
 1 hour

1820
 702 10th St. S.E.
 Washington

1957 to 1958

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 16. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

6665

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06659

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ioland Memorial Hospital				d. STREET ADDRESS 3900 Hamilton Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jeannette Middle Martin Last Miller				4. DATE OF DEATH Month June Day 11 Year 19 57			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-20-57		9. AGE (in years last birthday) yrs. 17	IF UNDER 1 YEAR Months 12 Days 12	IF UNDER 24 HRS. Hours 12 Min. 12
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Morton Stockdale Miller				14. MOTHER'S MAIDEN NAME Carol Martin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT J. Abert Miller; 5607 Clemson Rd College Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 721.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) Aspiration of stomach contents (c) Aspiration of stomach contents DUE TO (c) Aspiration of stomach contents							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Same as Part 2, Item 16					
20c. TIME OF INJURY Month, Day, Year 6-11 1957 p. m. 6:30		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) in automobile		20f. (City or town) Hyattsville, Pr. Geo. Md. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 11, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/12/57		22c. NAME OF CEMETERY OR CREMATORY Mt Carmel Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore County Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				24a. REC'D BY REGISTRAR June 14 57		24b. REGISTRAR'S SIGNATURE James H. Scott	

9VVVVVVVVXVV

BUREAU V. 81

JUN 14 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

6704

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06660

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hill Crest Heights</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hill Crest Heights</u>	
c. LENGTH OF STAY IN 1b <u>16 months</u>		d. STREET ADDRESS <u>2315 KIRBY Drive</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>PAUL</u> Middle <u>R.</u> Last <u>MOORE</u>		4. DATE OF DEATH Month <u>6</u> Day <u>11</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 15 1893</u>
9. AGE (In years, last birthday) <u>64</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>6</u> Days <u>16</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONDUCTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WASH TERMINAL</u>	
11. BIRTHPLACE (State or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM MOORE</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown, leave blank) <u>WORLD WAR</u>		16. SOCIAL SECURITY NO. <u>Betty Morris Moore</u>	
17. INFORMANT <u>Betty Morris Moore</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary thrombosis</u> DUE TO <u>coronary insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>2 hours</u> DUE TO (c) <u>2 1/2 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3-28-1957</u> , to <u>6-11-1957</u> , that I last saw the deceased alive on <u>6-11-1957</u> , and that death occurred at <u>9:15 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5731 23rd Parkway SE</u> DATE SIGNED <u>DAVID S. GORDON, M.D.</u> ACTUAL SIGNATURE <u>David S. Gordon</u> PHYSICIAN'S NAME (Type) <u>DAVID S. GORDON, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>6-12-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wilmington Md</u>	22d. LOCATION (City, town, or county) (State) <u>Del.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 12 '57</u>	
24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>			

RECEIVED

JUN 12 1957

BUREAU V. 5

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06661

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md		c. LENGTH OF STAY IN 1b D O A		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Palmer Park, Maryland.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 7709 Normandy Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last James Alfred Morris				4. DATE OF DEATH Month Day Year June 20, 1957 19			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 7, 1957	
9. AGE (In years last birthday) 6 weeks.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Cheverly Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Charles Morris				14. MOTHER'S MAIDEN NAME Helen Helms			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Charles Morris, Palmer Park Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John T. Maloney</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 20, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/21/57		22c. NAME OF CEMETERY OR CREMATORY Clover Creek Cemetery		22d. LOCATION (City, town, or county) (State) Mc Dowell Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch Sons				ADDRESS Hyattsville, Maryland.		24a. REC'D BY REGISTRAR DATE JUN 24 1957	
				24b. REGISTRAR'S SIGNATURE D. L. Smith			

RECEIVED

JUN 24 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6705

CERTIFICATE OF DEATH

Item 8-11-1957-1-1

Reg. Dist. No. 06662-11

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo's. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland		c. LENGTH OF STAY IN 1b 2 Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nursing Home		e. STREET ADDRESS 5001- Forestville Road S.E.	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ERNEST Middle G. Last MURRAY		4. DATE OF DEATH Month JUNE Day 7th. Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1899 19th March 1890
9. AGE (In years last birthday) 68 yrs		10. IF UNDER 1 YEAR Months Days Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Washington Gas. Co.	
11. BIRTHPLACE (State or foreign country) Washington, DC.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Murray		14. MOTHER'S MAIDEN NAME Jeanette Gage	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) 		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mrs Violet B. Murray		Address 5513- Parkland Court, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General Arteriosclerosis DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 30 min. Unknown un.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Had a cerebral (March 16 1957) hemorrhage		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 3312	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that I attended the deceased from March 16 19 57 to June 7 19 57 that I last saw the deceased alive on June 5 19 57 , and that death occurred at 4:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Paul Van Natta M.D. 5440-Silver Hill Rd. Suitland Md 6-7-57 PHYSICIAN'S NAME (Type) Paul Van Natta 5440--Silver Hill Rd. Suitland Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 8- 57	
22c. NAME OF CEMETERY OR CREMATORY Washington National		22d. LOCATION (City, town, or county) (State) Suitland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros.		1661- Good Hope Road S.E. Washington 20, D.C.	
24a. REC'D BY REGISTRAR JUN 10 1957		24b. REGISTRAR'S SIGNATURE 	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, or in any event within 72 hours after death.

RECEIVED
JUN 10 1957
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the cause of the delay in writing on the back of this certificate. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar promptly for burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

6667

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06663

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN 1b D.O.A.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ioland Memorial Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel			
				d. STREET ADDRESS Horseshoe Motel			
3. NAME OF DECEASED (Type or print) First John Middle Aden Last Myer				4. DATE OF DEATH Month June Day 18 Year 19 57			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 8-11-08	
9. AGE (In years last birthday) 48 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Navy Officer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kansas	
						12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John A. Myer				14. MOTHER'S MAIDEN NAME Cornelia Aden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1931-46		17. INFORMANT Mother; same address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Crushed chest DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Operator of an automobile in collision with another.					
20c. TIME OF INJURY Hour 9.30 p. m. Month, Day, Year 6-18-57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) N. Laurel, Howard County, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney		EXAMINER'S NAME (Type) John T. Maloney, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED June 20, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/21/57		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE H. Gasch's Sons				ADDRESS Hyattsville, Maryland.		24a. REC'D BY REGISTRAR JUN 24 1957	
						24b. REGISTRAR'S SIGNATURE James Henry	

RECEIVED

JUN 24 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6668

CERTIFICATE OF DEATH

06664

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>3 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>				e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lorenzo</u> Middle <u>D</u> Last <u>Pace</u>				4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 4, 94</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>VA.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Richard Pace</u>			
14. MOTHER'S MAIDEN NAME <u>Minnie Bowen</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>Mrs. Eliza P. Pace - 700-65th Ave. Seat Pleasant Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> DUE TO (b) <u>ileitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/26</u> <u>1957</u> , to <u>6/29</u> <u>1957</u> , that I last saw the deceased alive on <u>6/29</u> <u>1957</u> , and that death occurred at <u>9:10 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. E. Mussler</u> M.D.				DATE SIGNED <u>6/29/57</u>			
PHYSICIAN'S NAME (Type) <u>F. E. MUSSLER</u>				<u>Lanover Hills, Md.</u>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 2, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town or county) (State) <u>Smithard Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home 404 + Mass Ave NW</u>				24a. REC'D BY REGISTRAR <u>Wash DC</u>			
24b. REGISTRAR'S SIGNATURE <u>July 2-57 Edward F. Gillis</u>				DATE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SAU V. 81

3 1957

1 VED

6669

CERTIFICATE OF DEATH

06665

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Prince Georges County</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly,</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>Carl E. Pearson</u>				4. DATE OF DEATH Month Day Year <u>June 30 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-24-91</u>		9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Federal Government</u>		11 BIRTHPLACE (State or foreign country) <u>Iowa</u>		12 CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>John S. Pearson</u>				14 MOTHER'S MAIDEN NAME <u>Callie Mc Knight</u>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>1 1 1</u>		16 SOCIAL SECURITY NO. <u>1 1 1</u>		17 INFORMANT <u>Carl E. Pearson Jr</u> Address <u>5207 Lincoln Rd College Park, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosing Myocardial Infarction</u> DUE TO (c) <u>8 days</u>							INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Greenbelt</u>		(County) (State)	
21. I certify that I attended the deceased from <u>June 1952</u> to <u>June 30 1957</u> , that I last saw the deceased alive on <u>June 30 1957</u> , and that death occurred at <u>3:45 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Hans Wodak</u>				ADDRESS (Street, city or town, state) <u>30-c 4156E Rd. GREENBELT, MD. 20770</u>			
DATE SIGNED <u>6-30-57</u>							
PHYSICIAN'S NAME (Type) <u>Dr. Hans Wodak</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7/3/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) <u>Arlington Virginia</u>			
23 FUNERAL DIRECTOR'S SIGNATURE <u>F. Gutch's Sons Hyattsville, Maryland.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 2 '57</u>		24b. REGISTRAR'S SIGNATURE <u>Albeauch</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon flaps. Pages 1 and 2 should be filed with the registrar for use to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

1957

RECEIVED

6670

06666

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Prince George MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md				c. LENGTH OF STAY IN 1b 2 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandwine, Md.			
f. STREET ADDRESS Rt#1 Box 20				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Fannie Middle Pettus Last Pettus				4. DATE OF DEATH Month June Day 29 Year 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 19 1885	
9. AGE (In years lost birth day) 72 yrs.		IF UNDER 1 YEAR Months 12 Days 29 Hours 57 Min 57		IF UNDER 24 HRS Months 12 Days 29 Hours 57 Min 57			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) N. C.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME unk.				14. MOTHER'S MAIDEN NAME unk.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs David Reifschneider Address Brandywine, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Encephalopathy 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio Vascular Disease 10 years DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 6/27 , 19 57 , to 6/29 , 19 57 , that I last saw the deceased alive on 6/29 , 19 57 , and that death occurred at 7:15 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Norman Donat Ameau M.D.				ADDRESS (Street, city or town, state) 3503 Pennys ST DATE SIGNED 6/29/57			
PHYSICIAN'S NAME (Type) NORMAN DONAT AMEAU				MT PAINIER MD			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-3-57		22c. NAME OF CEMETERY OR CREMATORY Rock Hill Cem.		22d. LOCATION (City, town, or county) (State) Rock Hill, S. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Huntt Funeral Home ADDRESS Waldorf, Md.				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Waldorf	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06667

6706

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) STATE Maryland Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riggs Manor, Md				c. LENGTH OF STAY IN 1b 2 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2313 Woodberry Street,.				e. STREET ADDRESS 2313 Woodberry Street			
3. NAME OF DECEASED (Type or print) First Lottie R. Middle Pfaff Last				4. DATE OF DEATH Month JUNE Day 12 Year 1957			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 11, 1871	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U S A				13. FATHER'S NAME William E. Dixon			
14. MOTHER'S MAIDEN NAME Olivia Griffith				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO.				17. INFORMANT Ethel Loux Riggs Manor, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular hemorrhage 531X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Generalized Arteriosclerosis 10-15 yrs.						INTERVAL BETWEEN ONSET AND DEATH 2-3 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4-50.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Sept. 27, 1955, to JUNE 12, 1957, that I last saw the deceased alive on JUNE 5, 1957, and that death occurred at 8:30 AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert B. Irey				ADDRESS (Street, city or town, state) 7105 Riggs Rd. Hyattsville, Md			
PHYSICIAN'S NAME (Type) Robert B. Irey				DATE SIGNED JUN 17 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Interment		22b. DATE THEREOF 6/14/57		22c. NAME OF CEMETERY OR CREMATORY Philadelphia		22d. LOCATION (City, town, or county) (State) Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland.		24a. REC'D BY REGISTRAR DATE JUN 17 1957	
24b. REGISTRAR'S SIGNATURE W. Lebeck							

BUREAU V. 3

JUN 17 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. With the registrar provide burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

6671

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06668

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b Dead on arrival					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Alfred Middle Frederick Last Pischke				4. DATE OF DEATH Month June Day 14 Year 19 57					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 12, 1892			
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Warrant Officer				10b. BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Pennsylvania			
12. CITIZEN OF WHAT COUNTRY? U. S. A.									
13. FATHER'S NAME August F. Pischke				14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 26 years		17. INFORMANT Thomas E. Granishe, Forestville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Acute congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute congestive heart failure DUE TO (c) Acute congestive heart failure								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 a. m. <input type="checkbox"/> p. m. <input type="checkbox"/>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) Forestville				20g. (County) Prince George's		20h. (State) Md.			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE James I. Boyd				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED June 14, 1957	
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> X									
22a. BURIAL, CREMATION, REMOVAL, etc. Burial		22b. DATE THEREOF 6-18-1957		22c. NAME OF CEMETERY OR CREMATORY Arlington Hotel		22d. LOCATION (City, town, or county) 28 Myer, Va		(State) Va	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Wettingly				ADDRESS Wash DC		24a. REC'D BY REGISTRAR 17 57		24b. REGISTRAR'S SIGNATURE Robert A. Wettingly	

BUREAU V. S.

JUN 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06669

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Rainier	
f. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3324 Buchanan Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Margaret Anne Powell		4. DATE OF DEATH Month Day Year June 9, 1957	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 18, 1913
9. AGE (In years last birthday) 43 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Women's Apparel	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Leland Talbot		14. MOTHER'S MAIDEN NAME Charlotte Anne ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 577 34461	
17. INFORMANT Daniel Powell; same address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Intracranial hemorrhage and shock		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Fracture of base of skull		CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall down stairs, hitting head on basement floor.	
20c. TIME OF INJURY Month, Day, Year Hour 6:20 p.m. 6-9-57 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) a house		20f. (City or town) (County) (State) W. Lanham Hills. Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.			
ACTUAL SIGNATURE <i>John T. Maloney</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED June 9, 1957	
22a. BURIAL, CREMATION, REINTERMENT (Specify) Burial		22b. DATE THEREOF 12 June 1957	
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE F. GASCH'S SONS		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR DATE JUN 13 57		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

RECEIVED

JUN 18 1957

BUREAU V. 8

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6673

06670

Reg. Dist. No.

1. PLACE OF DEATH ■ COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale			c. LENGTH OF STAY IN 1b 30 min.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ieland Memorial Hospital				d. STREET ADDRESS Washington Tourists Court		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Joseph Middle Maurice Last Power				4. DATE OF DEATH Month June Day 5 Year 19 57				
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April , 1882		
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Musician			10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Maurice Power				14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 482-12-1232		17. INFORMANT Joseph H. Manning, Solomon's, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c), stating the underlying cause last. DUE TO							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE John T. Maloney NAME (Type) John T. Maloney, M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED June 5, 1957		
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 6-6-57		22c. NAME OF CEMETERY OR CREMATORY Lees' Crematorium		22d. LOCATION (City, town, or county) (State) Washington, D.C.		
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home				ADDRESS Washington D.C.		24a. REC'D BY REGISTRAR June 7 1957		
				24b. REGISTRAR'S SIGNATURE				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

BUREAU V. B.

UN 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6674

CERTIFICATE OF DEATH

Reg. Dist. No.

06671

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Heights 28 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Heights	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6127 - Bass Street		d. STREET ADDRESS 6107 - Bass Street	
3. NAME OF DECEASED (Type or print) MARY First LUCILLE Middle PRATHER Last		4. DATE OF DEATH June 18 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 27 1910 47 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	9. AGE (In years last b. day) 47 yrs.
11. BIRTHPLACE (State or foreign country) Indian Head Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Bonnie		14. MOTHER'S MAIDEN NAME Sarah Bonnie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Harry Prather - 6107 Bass Street		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Stomach IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 1, 1956, to June 18, 1957, that I last saw the deceased alive on June 18, 1957, and that death occurred at 11 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William Brainin M.D.		ADDRESS (Street, city or town, state) 6127 Central Ave DATE SIGNED 6/18/57	
PHYSICIAN'S NAME (Type) WM. BRAININ		Capitol Heights Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-22-57	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Shilford Maryland
23. FUNERAL DIRECTOR'S SIGNATURE 22 W. Chamber to 517-11th St. S.E.		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	

JUN 21 1957

RECEIVED

JUN 21 1957

BUREAU V. 3

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6707

06672

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence Before admission) a. STATE <u>Maryland</u> COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write nearest town) <u>Commody Hills</u>		c. LENGTH OF STAY IN Tb <u>3 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Commody Hills</u>		d. STREET ADDRESS <u>7507- Eads Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7507- Eads Street</u>				d. STREET ADDRESS <u>7507- Eads Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Riley Pruitt</u>				4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 15 1881</u>	
9. AGE in years last birthday <u>75</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS. Hours <u> </u> Min <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Heating</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>William Riley Pruitt</u>				14. MOTHER'S MARDEN NAME <u>Maria Moore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>William L. Pruitt</u> Address <u>5316 Taylor St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u> DUE TO <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>June 6, 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/10/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Natl.</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers</u> ADDRESS <u>5801 Cleveland Ave. Riverdale Md</u>				24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

MEDICAL CERTIFICATION

RECEIVED

JUN 10 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6708

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06673
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Forestville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5421 Pumphrey Drive		d. STREET ADDRESS 5421 Pumphrey Drive	
3. NAME OF DECEASED (Type or print) First Harry Middle Maurice Last Pumphrey		4. DATE OF DEATH Month June Day 15 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 8, 1889
9. AGE (In years (last birthday) yrs. 67		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Skilled laborer		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Enoch F. Pumphrey		14. MOTHER'S MAIDEN NAME Mary L. Hayes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Address Bertha Pumphrey Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 440.1 DUE TO Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 440-X 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James T. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) James T. Boyd		DATE SIGNED June 15, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-18-57	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Suitland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Jr. 517-11th St. S.E.		24. REC'D BY REGISTRAR JUN 18 1957	
ADDRESS		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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JUN 18 1957

BUREAU V. B.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06674

6675

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 2 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3507--56th Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle K Last PUMPHREY				4. DATE OF DEATH Month June Day 25th Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 13th, 1876	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter		10b. KIND OF BUSINESS OR INDUSTRY Rsetaurant	
11. BIRTHPLACE (State or foreign country) Oxon Hill, Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Richard Pumphrey				14. MOTHER'S MAIDEN NAME [Unknown] Palmer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 577-26-5593		17. INFORMANT Helen Clay, 3507--56th St. Cheverly, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition 150.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility DUE TO (c) Atherosclerosis						INTERVAL BETWEEN ONSET AND DEATH 14yr 10yr 10yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 715x Rectal ulcer over sacrum						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1 Jan., 1957 , to 25 Jan., 1957 that I last saw the deceased alive on 23 June 1957 , and that death occurred at 4:00A M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John Kehoe M.D.				ADDRESS (Street, city or town, state) 3404 Cheverly Ave.,			
PHYSICIAN'S NAME (Type) JOHN KEHOE				DATE SIGNED 6/25/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/29/1957		22c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				24a. REC'D BY REGISTRAR DATE JUN 28 57		24b. REGISTRAR'S SIGNATURE W. W. Chambers	

RECEIVED
JUN 28 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item # 16-10-57 et

CERTIFICATE OF DEATH

06675

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesley				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover			
c. LENGTH OF STAY IN 1b 7 Days				d. STREET ADDRESS 1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James		Middle E		Last Queen		4. DATE OF DEATH Month June Day 2 Year 1957	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 22, 1913		9. AGE (In years last birthday) 44 yrs.	IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Gov't		11. BIRTHPLACE (State or foreign country) Seat Pleasant, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Queen				14. MOTHER'S MAIDEN NAME Martha			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mary Queen 1647 West Virginia Ave., N.E.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 1 X X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Glomerulo-nephritis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 5/27, 1957 , to 6/2, 1957 , that I last saw the deceased alive on 6/2, 1957 , and that death occurred at 4:10 P.M. , from the causes and on the date stated above. Max M. Herzberg ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE				M.D.			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/8/1957	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) D.C. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE J. T. Stewart ADDRESS 30 N. St. N.E.				24a. REC'D BY REGISTRAR DATE JUN 7 57		24b. REGISTRAR'S SIGNATURE W. Smith	

BUREAU V. S.

JUN 7 1957

RECEIVED

6709

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews Air Force Base		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Forestville, Maryland X 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1401st USAF Hospital, Andrews AFB		d. STREET ADDRESS 3314 Lorrington Drive	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Ann Rable		4. DATE OF DEATH Month Day Year June 27 1957	
5. SEX Female	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 23 November 1954
9. AGE (in years last birthday) 2 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not applicable		10b. KIND OF BUSINESS OR INDUSTRY Not Applicable	
11. BIRTHPLACE (State or foreign country) Bolling AF Base Hospital Bolling AFB, Wash 25, D.C.		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Frank P. Rable		14. MOTHER'S MAIDEN NAME Catherine Ruth Bly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Not applicable		16. SOCIAL SECURITY NO Not Applicable	
17. INFORMANT Frank P. Rable (Father)		Address 3314 Lorrington Drive North Forestville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 705.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cellulitis, left leg DUE TO (c) Abrasion, left knee			INTERVAL BETWEEN ONSET AND DEATH 2 Days 3 Days 6 Days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Paralytic ileus			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Innocent Fall		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour Min. P. M. June 21 1957 1:30 p. m.	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	20f. (City or town) (County) (State) N. Forestville Prince Georges, Maryland
21. I certify that I attended the deceased from 26 June 1957, to 27 June 1957, that I last saw the deceased alive on 27 June 1957, and that death occurred at 8:30 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles L. Picus		ADDRESS (Street, city or town, state) 1401st USAF Hospital, Andrews AFB	
DATE SIGNED 27 June 57			
PHYSICIAN'S NAME (Type) CHARLES L. PICUS, Captain, USAF (C) Andrews AFB, Washington 25, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 29, 1957	22c. NAME OF CEMETERY OR CREMATORY Wilkes-Barre, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Gallucci		ADDRESS 1756 Pa. Washington, DC	
24a. REC'D BY REGISTRAR DATE JUN 5 '57		24b. REGISTRAR'S SIGNATURE J. W. Gallucci	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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JUL 5 1967

BUREAU V. E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6677

CERTIFICATE OF DEATH

06677

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Pr. Geo's. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo's.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ Naylor,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pr. Geo's. General Hospital				d. STREET ADDRESS ---			
3. NAME OF DECEASED (Type or print) First James Middle Wilson Last Rawlings				4. DATE OF DEATH Month June Day 24 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 10, 1897	9. AGE (In years lost birthday) yrs. 60	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocery Business		10b. KIND OF BUSINESS OR INDUSTRY Own Store		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James William Rawlings				14. MOTHER'S MAIDEN NAME Bessie W. Perrie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. --		17. INFORMANT Rawlings		Address Mrs. Grace Wix Naylor, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Right Lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) with metastases to Liver DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) Baden		(County) (State)	
21. I certify that I attended the deceased from Mar 3, 19 57 to June 24, 19 57 , that I last saw the deceased alive on June 24, 19 57 , and that death occurred at 1:20 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE James G. Sasscer M.D.				ADDRESS (Street, city or town, state) Upper Marlboro - Md.			
PHYSICIAN'S NAME (Type) James G. Sasscer, M.D.				DATE SIGNED 6-24-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/26/57		22c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		22d. LOCATION (City, town, or county) (State) Baden Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros.				ADDRESS Upper Marlboro, Md.		24a. REC'D BY REGISTRAR June 28 57	
				24b. REGISTRAR'S SIGNATURE Overman			

RECEIVED

JUN 28 1957

BUREAU OF

6678

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Prince George MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesley, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md.			
c. LENGTH OF STAY IN 1b D O A				d. STREET ADDRESS 4110 Emerson Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) Paul Rea				4. DATE OF DEATH June 12 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 6, 1880	
9. AGE (In years last birthday) 77		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Grnsite Works		11. BIRTHPLACE (State or foreign country) Washington D. C.	
12. CITIZEN OF WHAT COUNTRY? U S A				13. FATHER'S NAME William Rea			
14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no			
16. SOCIAL SECURITY NO. no				17. INFORMANT Henry Rea - (Son) Address Hyattsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH 15 hrs	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 427.0 DUE TO coronary occlusion							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) anterior chest heart area							
DUE TO (c) year							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 19 57 to June 19 57 that I last saw the deceased alive on June 12 19 57 and that death occurred at 12:55 PM from the causes and on the date stated above.							
ACTUAL SIGNATURE V. E. Rea M.D.				ADDRESS (Street, city or town, state) Hyattsville Md		DATE SIGNED 6/12/57	
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/14/57		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Maryland.				24a. REC'D BY REGISTRAR June 17 57		24b. REGISTRAR'S SIGNATURE Alb. Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for a burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 17 1957

RECEIVED

6679

CERTIFICATE OF DEATH

06679

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGES GEN. HOSP.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SEAT PLEASANT	
f. STREET ADDRESS 7529 Central Avenue		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOHN L. REDMILES		4. DATE OF DEATH Month Day Year JUNE 8 1957	
5. SEX MALE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-23-86
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Empl'd. Electrician Transit Co.		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Lemuel Redmiles		14. MOTHER'S MAIDEN NAME Mary Ann Shoemaker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO ---	
17. INFORMANT Mrs. Lillie E. Hampton-Seat Pleasant, Md.		Address 7529 Central Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 150X DUE TO Co of Emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hemorrhage (c) Cardiac Failure		INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/8 , 19 57 , to 6/8 , 19 57 , that I last saw the deceased alive on 6/8 , 19 57 , and that death occurred at 5:50 A. M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) Prince Geo's Gen. Hospital, Cheverly, Md.		DATE SIGNED 6/8/57	
ACTUAL SIGNATURE Max M. Herzberg M.D.			
PHYSICIAN'S NAME (Type) MAX M. HERZBERG			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/11/57	22c. NAME OF CEMETERY OR CREMATORY Trinity Cemetery	22d. LOCATION (City, town, or county) (State) Patuxant Station Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home—Upper Marlboro, Md.		ADDRESS Upper Marlboro, Md.	
24a. REC'D BY REGISTRAR June 12 '57		24b. REGISTRAR'S SIGNATURE Arthur	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 12 1957

RECEIVED

6680

CERTIFICATE OF DEATH

06680

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Prince George MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Md. c. COUNTY Pg/	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md		c. LENGTH OF STAY IN 1b 2 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince George General		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn, Md	
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince George General		d. STREET ADDRESS 6900 Freeport St/	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) Stephen Joseph Baby Boy Middle Reilly		4. DATE OF DEATH Month June Day 27 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-25-57
9. AGE (In years, low birth days) 2 1/2 yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James F. Reilly		14. MOTHER'S MAIDEN NAME Margaret H. Hawes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT James F. Reilly		Address Same as # 2 Father	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Atrial Fibrillation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Infarction DUE TO Heart & Myocardium (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 to 19, that I last saw the deceased alive on 19 and that death occurred at 12:00 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Albert Roth		M.D. Riverdale, Md 6/27/57	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/28/57	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland	
24a. REC'D BY REGISTRAR DATE JUL 3 '57		24b. REGISTRAR'S SIGNATURE	

2077263XV3

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 1 and 2 should be filed with the registrar to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

1957

DEAD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for a burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06681

6710

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont Heights		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2. Fairmont Heights	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 613 60th Place		d. STREET ADDRESS 613 60th Place	
3. NAME OF DECEASED (Type or print) First Middle Last Nancy J. Roberts		4. DATE OF DEATH Month Day Year June 4, 1957	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/3/1874
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Corbin		14. MOTHER'S MAIDEN NAME Mary E. Sinclair	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Charles Roberts, Jr.		Address 613 60th Pl., Fairmont Heights, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerosis - Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH 18 yrs. 4 days 7 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 10 th , 1957, to June 4 th , 1957, that I last saw the deceased alive on June 4 th , 1957, and that death occurred at 316 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE W. H. BRUCE		DATE SIGNED 6-4-57	
PHYSICIAN'S NAME (Type) W. H. BRUCE, MD		ADDRESS (Street, city or town, state) 3847 Mass Ave. N.E.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/9/1957	
22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Alexandria, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R. M. M. M. M.		ADDRESS 1820 9th S., N.W.	
24a. REC'D BY REGISTRAR JUN 10 1957		24b. REGISTRAR'S SIGNATURE	

RECEIVED

UN 10 1957

BUREAU V. A.

CERTIFICATE OF DEATH

07800
Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Prince George				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Pg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cottage City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				d. STREET ADDRESS 3705 41st. Ave.			
3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy Robertson				4. DATE OF DEATH Month Day Year June 28 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-27-57	9. AGE (In years last birthday) 7 hrs 15 min	IF UNDER 1 YEAR IF UNDER 24 HRS		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Horace Clifford Robertson				14. MOTHER'S MAIDEN NAME Marie Alice Lysikowski			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO		17. INFORMANT Marie (Mother) Address Same As above	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Atelectasis Prematurity INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 6/27 1952 to 6/28 1957, that I last saw the deceased alive on 6/28 1957, and that death occurred at 3:45 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 5301 Hamilton St., Hyattsville 6/28/57							
ACTUAL SIGNATURE John W. Purkin				PHYSICIAN'S NAME (Type) M.D. 5301 Hamilton St., Hyattsville			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
Burial Only 1957				June 28 1957		Prince Georges In Hosp Cheverly Md	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR	
Henry M. Ramo Jr				Arden		DATE JUL 20 57	
24b. REGISTRAR'S SIGNATURE							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar. The registrar may, at his discretion, require burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. K.

JUL 22 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

6711
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 1-2-3-4-5-6-7-8-9-10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100-101-102-103-104-105-106-107-108-109-110-111-112-113-114-115-116-117-118-119-120-121-122-123-124-125-126-127-128-129-130-131-132-133-134-135-136-137-138-139-140-141-142-143-144-145-146-147-148-149-150-151-152-153-154-155-156-157-158-159-160-161-162-163-164-165-166-167-168-169-170-171-172-173-174-175-176-177-178-179-180-181-182-183-184-185-186-187-188-189-190-191-192-193-194-195-196-197-198-199-200-201-202-203-204-205-206-207-208-209-210-211-212-213-214-215-216-217-218-219-220-221-222-223-224-225-226-227-228-229-230-231-232-233-234-235-236-237-238-239-240-241-242-243-244-245-246-247-248-249-250-251-252-253-254-255-256-257-258-259-260-261-262-263-264-265-266-267-268-269-270-271-272-273-274-275-276-277-278-279-280-281-282-283-284-285-286-287-288-289-290-291-292-293-294-295-296-297-298-299-300-301-302-303-304-305-306-307-308-309-310-311-312-313-314-315-316-317-318-319-320-321-322-323-324-325-326-327-328-329-330-331-332-333-334-335-336-337-338-339-340-341-342-343-344-345-346-347-348-349-350-351-352-353-354-355-356-357-358-359-360-361-362-363-364-365-366-367-368-369-370-371-372-373-374-375-376-377-378-379-380-381-382-383-384-385-386-387-388-389-390-391-392-393-394-395-396-397-398-399-400-401-402-403-404-405-406-407-408-409-410-411-412-413-414-415-416-417-418-419-420-421-422-423-424-425-426-427-428-429-430-431-432-433-434-435-436-437-438-439-440-441-442-443-444-445-446-447-448-449-450-451-452-453-454-455-456-457-458-459-460-461-462-463-464-465-466-467-468-469-470-471-472-473-474-475-476-477-478-479-480-481-482-483-484-485-486-487-488-489-490-491-492-493-494-495-496-497-498-499-500-501-502-503-504-505-506-507-508-509-510-511-512-513-514-515-516-517-518-519-520-521-522-523-524-525-526-527-528-529-530-531-532-533-534-535-536-537-538-539-540-541-542-543-544-545-546-547-548-549-550-551-552-553-554-555-556-557-558-559-560-561-562-563-564-565-566-567-568-569-570-571-572-573-574-575-576-577-578-579-580-581-582-583-584-585-586-587-588-589-590-591-592-593-594-595-596-597-598-599-600-601-602-603-604-605-606-607-608-609-610-611-612-613-614-615-616-617-618-619-620-621-622-623-624-625-626-627-628-629-630-631-632-633-634-635-636-637-638-639-640-641-642-643-644-645-646-647-648-649-650-651-652-653-654-655-656-657-658-659-660-661-662-663-664-665-666-667-668-669-670-671-672-673-674-675-676-677-678-679-680-681-682-683-684-685-686-687-688-689-690-691-692-693-694-695-696-697-698-699-700-701-702-703-704-705-706-707-708-709-710-711-712-713-714-715-716-717-718-719-720-721-722-723-724-725-726-727-728-729-730-731-732-733-734-735-736-737-738-739-740-741-742-743-744-745-746-747-748-749-750-751-752-753-754-755-756-757-758-759-760-761-762-763-764-765-766-767-768-769-770-771-772-773-774-775-776-777-778-779-780-781-782-783-784-785-786-787-788-789-790-791-792-793-794-795-796-797-798-799-800-801-802-803-804-805-806-807-808-809-810-811-812-813-814-815-816-817-818-819-820-821-822-823-824-825-826-827-828-829-830-831-832-833-834-835-836-837-838-839-840-841-842-843-844-845-846-847-848-849-850-851-852-853-854-855-856-857-858-859-860-861-862-863-864-865-866-867-868-869-870-871-872-873-874-875-876-877-878-879-880-881-882-883-884-885-886-887-888-889-890-891-892-893-894-895-896-897-898-899-900-901-902-903-904-905-906-907-908-909-910-911-912-913-914-915-916-917-918-919-920-921-922-923-924-925-926-927-928-929-930-931-932-933-934-935-936-937-938-939-940-941-942-943-944-945-946-947-948-949-950-951-952-953-954-955-956-957-958-959-960-961-962-963-964-965-966-967-968-969-970-971-972-973-974-975-976-977-978-979-980-981-982-983-984-985-986-987-988-989-990-991-992-993-994-995-996-997-998-999-1000-1001-1002-1003-1004-1005-1006-1007-1008-1009-1010-1011-1012-1013-1014-1015-1016-1017-1018-1019-1020-1021-1022-1023-1024-1025-1026-1027-1028-1029-1030-1031-1032-1033-1034-1035-1036-1037-1038-1039-1040-1041-1042-1043-1044-1045-1046-1047-1048-1049-1050-1051-1052-1053-1054-1055-1056-1057-1058-1059-1060-1061-1062-1063-1064-1065-1066-1067-1068-1069-1070-1071-1072-1073-1074-1075-1076-1077-1078-1079-1080-1081-1082-1083-1084-1085-1086-1087-1088-1089-1090-1091-1092-1093-1094-1095-1096-1097-1098-1099-1100-1101-1102-1103-1104-1105-1106-1107-1108-1109-1110-1111-1112-1113-1114-1115-1116-1117-1118-1119-1120-1121-1122-1123-1124-1125-1126-1127-1128-1129-1130-1131-1132-1133-1134-1135-1136-1137-1138-1139-1140-1141-1142-1143-1144-1145-1146-1147-1148-1149-1150-1151-1152-1153-1154-1155-1156-1157-1158-1159-1160-1161-1162-1163-1164-1165-1166-1167-1168-1169-1170-1171-1172-1173-1174-1175-1176-1177-1178-1179-1180-1181-1182-1183-1184-1185-1186-1187-1188-1189-1190-1191-1192-1193-1194-1195-1196-1197-1198-1199-1200-1201-1202-1203-1204-1205-1206-1207-1208-1209-1210-1211-1212-1213-1214-1215-1216-1217-1218-1219-1220-1221-12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RECEIVED

JUL 4 1957

BUREAU V. S.

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Res dence before adm ssion) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews Air Force Base				c. LENGTH OF STAY IN 1b 1 Yr. 10 mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11-2-3-232 - Base Area				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Heights			
f. STREET ADDRESS 4901 Leisure Drive				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EDMUND First ENTRY Middle ROSENTHAL Last				4. DATE OF DEATH Month June Day 10 Year 1957			
5. SEX Male		6. COLOR OR RACE Oau		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 4, 1920	
9. AGE (In years last birthday) 37 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS. Months Days Hours Min		12. IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pilot				10b. KIND OF BUSINESS OR INDUSTRY U.S. Air Force		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? United States				13. FATHER'S NAME Edmund Rosenthal			
14. MOTHER'S MAIDEN NAME Natalie Conrad				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or service) WWII Reverse			
16. SOCIAL SECURITY NO. 165-11-3415				17. INFORMANT Personnel Records Address 1401st Operations Group 3/307 FALMUS d. LUTIN Andrews AFB, Wash. 25, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbonmonoxide Poisoning 978.5 DUE TO Suicide Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Suicide DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 13 June 19 57 , to 13 June 19 57 , that I last saw the deceased alive on 13 June 19 57 , and that death occurred at M , from the causes and on the date stated above. Actual Signature Charles W. De Baun M.D. ADDRESS (Street, city or town, state) 1401st USAF Hospital DATE SIGNED 13 June 1957 PHYSICIAN'S NAME (Type) CHARLES W. DE BAUN, Colonel USAF (MC) Andrews Air Force Base Washington 25, D. C.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 18 June 1957			
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery				22d. LOCATION (City, town, or county) (State) Arlington, Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Jr. ADDRESS 517-11 St. S.E.				24a. REC'D BY REGISTRAR DATE JUN 18 57			
24b. REGISTRAR'S SIGNATURE Paul							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SERVICE DATA WW II

5 May 1941 to 20 March 1946
21 March 1946 to 16 December 1948
17 December 1948 to present

Active Service
Inactive Service
Active Service USAF

Item 21: I certify that I attended the deceased on 13 June 1957, this after being summoned to scene of death by USAF authorities, Andrews Air Force Base, Washington 25, D. C., Upon my arrival at the scene I confirmed death. Time of death could not be determined by my examination, however, the gross appearance of the body was one of at least a 2 or 3 day duration. I arrived at scene of death at 4:00 P.M., June 13, 1957.

Charles W. De Baun

CHARLES W. DE BAUN, Colonel USAF (MC) 1401st USAF Hospital
Andrews Air Force Base
Washington 25, D. C.

BUREAU V. S.

JUN 18 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

6713

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06684

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leesburg Heights</u> 23 years				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leesburg Heights</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7102 Foster Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>(HORRIFIC) Harace Edgar Rush</u>				4. DATE OF DEATH Month <u>June</u> Day <u>7</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 17, 1897</u> 60 yrs.	
9. AGE (In years last birthday) <u>60</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book Keeper Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Missouri</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Harace Rush</u>				14. MOTHER'S MAIDEN NAME <u>Holly Jane Anderson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr. Nancy Mitchell</u> Address <u>same as dec'd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4341</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-10-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>		22d. LOCATION (City, town or county) (State) <u>Switzland Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. Washington, D.C.</u>				24a. REC'D BY REGISTRAR <u>DATE JUN 12 '57</u>		24b. REGISTRAR'S SIGNATURE <u>W. W. Chambers</u>	

DATE SIGNED

June 7, 1957

RECEIVED

11 10 1957

RECEIVED

6618

CERTIFICATE OF DEATH

06685

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) b. STATE Maryland c. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 167th Rainier	
d. NAME OF HOSPITAL (If not in hosp. bldg., give street address) OR INSTITUTION 4708-31st Place		d. STREET ADDRESS 4708-31st Place	
3. NAME OF DECEASED (Type or print) James Michael Ryan		4. DATE OF DEATH June 8th 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/28/1902
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Southern Railway Auditor, Ret.		11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Joseph Ryan	
14. MOTHER'S MAIDEN NAME Catherine Gilligan		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO.		17. INFORMANT Amy Margaret Ryan (Wife)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Amyotrophic Lateral Sclerosis 356.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1957, 19, to June 8, 1957, that I last saw the deceased alive on June 3, 1957, and that death occurred at 4:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Ronald S. Fleischer (M.D.)		ADDRESS (Street, city or town, state) 4432 QUEENS CHAPEL Rd. Hyattsville, Md.	
DATE SIGNED 6/8/57		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 6-11-1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	
22d. LOCATION (City, town, or county) (State) Washington, D.C.		23. FUNERAL DIRECTOR'S SIGNATURE Kelly's Funeral Home	
ADDRESS 167th Rainier, Md.		24a. REC'D BY REGISTRAR DATE 11 1957	
24b. REGISTRAR'S SIGNATURE			

RECEIVED
JUN 11 1957
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6682 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06688

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mount Rainier			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 4307 Russell Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Rudolph Last Schuetzler				4. DATE OF DEATH Month June Day 15 Year 1957			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 10, '02		9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months 54 Days 54 Hours 54 Min.	IF UNDER 24 HRS. Hours 54 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Instrument maker		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Rudolph Schuetzler				14. MOTHER'S MAIDEN NAME Clara Boehmelte			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 107-09-6674		17. INFORMANT Address Rudolph G. Schuetzler; Hyattsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 14d X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Switland, Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 15, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/14/57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Switland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.				ADDRESS 5801 Cleveland Ave Riverdale, Md.		24. REC'D BY REGISTRAR JUN 18	
				24b. REGISTRAR'S SIGNATURE			

I

RECEIVED

JUN 18 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6616

CERTIFICATE OF DEATH

Reg. Dist. No.

06687 245
~~06687~~

1. PLACE OF DEATH a. COUNTY <u>Prince George's Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Hyattsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARLINGTON - 7, VA.</u>	
c. LENGTH OF STAY IN 1b <u>2 yrs 3 mos 10 da</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MS S BILL'S NURSING HOME FOR CHILDREN</u>		d. STREET ADDRESS <u>3134 N. THOMAS ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>Cheryl</u> Middle <u>Ann</u> Last <u>Scotfield</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>9</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 22 - 1954</u>
9. AGE (In years last birthday) <u>2</u> yrs.		IF UNDER 1 YEAR: Months <u>10</u> Days <u>18</u> IF UNDER 24 HRS. Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Scotfield</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Oakley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertension</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>6/9</u> , 19 <u>57</u> , and that death occurred at _____ M, from the causes and on the date stated above.		
ACTUAL SIGNATURE <u>Thomas A. Christensen</u> M.D.	ADDRESS (Street, city or town, state) <u>College Park, Md</u>	DATE SIGNED <u>6/8/57</u>
PHYSICIAN'S NAME (Type)		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 10, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Indian Mound Cemetery</u>
22d. LOCATION (City, town, or county) <u>Moravian</u>		(State) <u>N. Y.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. M. Evans</u>	ADDRESS <u>2841 Wilson Blvd, Wash, D.C.</u>	24a. REC'D BY REGISTRAR <u>6-57</u>
24b. REGISTRAR'S SIGNATURE <u>Amos G. Sever</u>		

RECEIVED

JUN 14 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6683

CERTIFICATE OF DEATH

06688

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Res. den. before admission) o STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>	
c. LENGTH OF STAY IN 1b <u>5 YEARS</u>		d. STREET ADDRESS <u>6011-TAYLOR ROAD, RIVERDALE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private home - Item #2.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>BRIDGET AGNES SHARKEY</u>		4. DATE OF DEATH Month Day Year <u>JUNE 13 1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 14, 1876</u>
9 AGE (In years last birthday) <u>81</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>ENGLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>OWEN SHARKEY</u>		14. MOTHER'S MAIDEN NAME <u>BRIDGET DWYER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO <u>165-09-2485A</u>	
17. INFORMANT <u>THOMAS KANE</u>		Address <u>6011-TAYLOR ROAD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Vascular Accident, Hypertension</u> DUE TO (c) <u>Arteriosclerotic Cerebral Vascular Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>2 weeks</u> <u>—</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>201X</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb</u> , 1954, to <u>June 13</u> , 1957, that I last saw the deceased alive on <u>June 1st</u> , 1957, and that death occurred at <u>10:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Gordon W. Kelley M.D. 6124-46th Ave. Hyattsville, Md 6/14/57</u>			
ACTUAL SIGNATURE <u>Gordon W. Kelley</u>		PHYSICIAN'S NAME (Type) <u>Gordon W. Kelley</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>NONE</u>	22b. DATE THEREOF <u>JUNE 18 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HOLY SEPULCHER</u>	22d. LOCATION (City, town, or county) (State) <u>PHILADELPHIA, PA</u>
23 FUNERAL DIRECTOR'S SIGNATURE <u>P. J. Staffell</u>		24a. REC'D BY REGISTRAR <u>James Henry</u>	
ADDRESS <u>475-H 7th St. Baltimore</u>		24b. REGISTRAR'S SIGNATURE <u>James Henry</u>	

BUREAU V. S.

JUN 17 1957

RECEIVED

6714

CERTIFICATE OF DEATH

06689

Reg. Dist. No.

242

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Va</u> b. COUNTY <u>Northampton</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Seat Pleasant</u> c. LENGTH OF STAY IN b <u>6 mos</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cape Charles</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				d. STREET ADDRESS <u>Washington Ave</u> <input type="checkbox"/> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Racheal</u> First <u>Smith</u> Middle <u>—</u> Last <u>—</u>			DATE OF DEATH <u>June</u> Month <u>1</u> Day <u>19</u> Year <u>57</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>—</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>W. Virginia</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Calvin Smith</u>			14. MOTHER'S MAIDEN NAME <u>Racheal Smith</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>no</u>		17. INFORMANT <u>Adell Trower</u> Address <u>Rt #1 366A Landover, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Congestive Heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar</u> , 1957, to <u>May</u> , 1957, that I last saw the deceased alive on <u>Mar 31</u> , 1957, and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. Henry C. Wise</u>				ADDRESS (Street, city or town, state) <u>9005 Volta St, Lanham, Md</u> DATE SIGNED <u>4/6/57</u>			
PHYSICIAN'S NAME (Type) <u>Henry A. Wise</u>				City, town, or county <u>Lanham, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 5</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cape Charles, Cem. Cape Charles, Va.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Joyner</u> ADDRESS <u>116 Mass. Ave N.W. Washington, D.C.</u>				24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Combs</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 5 1967

BUREAU V. S.

TO **LEGAL EXAMINER**: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO **FUNERAL DIRECTOR**: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

6715

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06690

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Allentown</u>		c. LENGTH OF STAY IN 1b <u>38 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Allentown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7805-Allentown Rd SE</u>				d. STREET ADDRESS <u>7805-Allentown Rd</u>			
3. NAME OF DECEASED (Type or print) <u>John James Ramsay Steed</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH Month <u>June</u> Day <u>19</u> Year <u>1957</u>	
9. AGE (Years, Months, Days) <u>53</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.-A</u>	
13. FATHER'S NAME <u>Lowe E Steed</u>				14. MOTHER'S MAIDEN NAME <u>Helen Gannon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name of branch) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Helen E. Steed, same as #2</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Angiocardiosis</u> DUE TO <u>Chronic emphysema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u>		EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>June 19, 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial June 22-57</u>		22b. DATE THEREOF <u>June 22-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sted Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Allentown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Common Bros. 1661-44 Hager</u>		ADDRESS <u></u>		24a. RECEIVED BY REGISTRAR <u>JOHN 24 1957</u>		24b. REGISTRAR'S SIGNATURE <u>A. H. Smith</u>	

SE 24th DE

RECEIVED

JUN 24 1957

BUREAU V. S.

06691

66:9

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT Rainer</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>16 MT Rainer</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4222-30th STREET</u>		d. STREET ADDRESS <u>4222-30th ST.</u>	
3. NAME OF DECEASED (Type or print) <u>James Fulton Suite Jr.</u>		4. DATE OF DEATH <u>6-23-1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 10, 1883</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Steven Suite</u>		14. MOTHER'S MAIDEN NAME <u>Alma Hardy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-05-5921</u>	
17. INFORMANT <u>Evac Suite</u>		Address <u>4222-30th ST MT Rainer MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory Failure</u> <u>190x</u> DUE TO <u>Carcinomatosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Melanoma Left Shoulder</u> (c) <u>Lymphedema-Left ant. mediastinum</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>3 years</u> <u>2 1/2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Lymphedema-Left ant. mediastinum</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>57</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 12, 1957</u> , to <u>June 23, 1957</u> , that I last saw the deceased alive on <u>June 22, 1957</u> , and that death occurred at <u>13th</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph H. Watson</u>		DATE SIGNED <u>June 23, 1957</u>	
PHYSICIAN'S NAME (Type) <u>James H. Watson</u>		ADDRESS (Street, city or town, state) <u>1400 Hope St NW Washington DC</u>	
22a. BURIAL, CREMATION, or other disposal (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-26-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>HOPE CHAPEL</u>		22d. LOCATION (City, town, or county) (State) <u>EDGEWATER MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Jr.</u>		24a. REC'D BY REGISTRAR <u>James H. Watson</u>	
24b. REGISTRAR'S SIGNATURE <u>James H. Watson</u>		24c. DATE <u>June 23, 1957</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 25 1967

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6684

06692

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capital Heights</u>		c. LENGTH OF STAY IN 1b <u>46 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capital Heights</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6120 C Street</u>				d. STREET ADDRESS <u>6120 C Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Harthe May Swick</u>				4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 20, 1883</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Month <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery Store</u>		11. BIRTH PLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. C.</u>	
13. FATHER'S NAME <u>Albert H. Haught</u>				14. MOTHER'S MAIDEN NAME <u>Harthe Swick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Clarence Swick, payee as #2</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra Cranial Hemorrhage</u> DUE TO <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type or print) <u>JAMES I. BOYD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/18/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suicide</u> <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Wm. Lee Sons, 700-4th St. N.E., N.C.</u>				24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	

DATE SIGNED

June 15, 1957

BUREAU V. E.

JUN 19 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06693

CERTIFICATE OF DEATH

Reg. Dist. No.

2451

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale Md		c. LENGTH OF STAY IN 1b 5 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Y/ Riverdale Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Good Luck Road			d. STREET ADDRESS Good Luck Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Louise Teske			4. DATE OF DEATH Month Day Year June 14, 1957 19		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 20, 1861		9. AGE (In years last birthday) 95 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own Home		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? U S A			13. FATHER'S NAME Unknown		
14. MOTHER'S MAIDEN NAME Unknown			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		
16. SOCIAL SECURITY NO. no			17. INFORMANT Vincent A Teske Address 4612 Georgia Ave NW Washington D. C.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 6 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21. I certify that I attended the deceased from 1952, to 6-14, 1957, that I last saw the deceased alive on 6-13, 1957, and that death occurred at 2 A. M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Leonard Hays		ADDRESS (Street, city or town, state) M.D. 5201 Balt Ave. Hyattsville Md			
PHYSICIAN'S NAME (Type) F. Gasch's Sons Hyattsville, Maryland.		DATE SIGNED 6-15-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/17/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 19 1957	
F. Gasch's Sons Hyattsville, Maryland.		James Levey		24b. REGISTRAR'S SIGNATURE	

RECEIVED

JUN 19 1957

BUREAU V. S.

6716

CERTIFICATE OF DEATH

Reg. Dist. No. 06694

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY PRINCE GEORGE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRANDYWINE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRANDYWINE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION NONE				d. STREET ADDRESS /			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) ALBERT W. TOWNSHEND				4. DATE OF DEATH JUNE 5 1957			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 21, 1878	
9. AGE (In years last birthday) 78		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME JOHN G. TOWNSHEND				14. MOTHER'S MAIDEN NAME ELIZABETH TOWNSHEND			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. —			
17. INFORMANT John O. Townshend, Brandywine, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO ARTERIOSCLEROSIS, GENERALIZED ADVANCED Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SENILITY. (c) SENILITY.				INTERVAL BETWEEN ONSET AND DEATH 1 HOUR 3 YEARS.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 5, 1957 to June 5, 1957 , that I last saw the deceased alive on June 5, 1957 , and that death occurred at Brandywine, Md. from the causes and on the date stated above.							
ACTUAL SIGNATURE Alfred R. Lapin M.D.				DATE SIGNED 6/6/57			
PHYSICIAN'S NAME (Type) ALFRED R. LAPIN							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		6-7-57		St. Peter's Cemetery		Brandywine, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home, Waldorf, Md.				24a. REC'D BY REGISTRAR June 10 1957			
ADDRESS				24b. REGISTRAR'S SIGNATURE Alfred R. Lapin			

BUREAU V. S.

JUN 10 1907

RECEIVED

6717

06695

CERTIFICATE OF DEATH

Reg. Dist. No.

142

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillside c. LENGTH OF STAY IN b 12 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1325--56th Ave., SE		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. XXXX Geo's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Hillside d. STREET ADDRESS 1325- 56th. Ave. S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JEANNE Middle TRON Last TRON		4. DATE OF DEATH Month June Day 2nd. Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 27- 1868
9. AGE (In years last birthday) 88		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic.	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry P. Pascal		14. MOTHER'S MAIDEN NAME Ann Poet	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 434.1	
17. INFORMANT Mrs. Lina Di Giulian (Dau.)		Address 1325- 56th Ave., S.E.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO Arteriosclerotic Cardiovascular Disease (c) Arteriosclerotic Cardiovascular Disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 434.1		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4/1 19 57 , to 6/2 19 57 , that I last saw the deceased alive on 5/31 19 57 , and that death occurred at 4A M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 2901 Fairlawn St SE DATE SIGNED 6/2/57	
ACTUAL SIGNATURE David Leonarduzzi M.D.		PHYSICIAN'S NAME (Type) David Leonarduzzi	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-3-57	22c. NAME OF CEMETERY OR CREMATORY Waldensian Cemetery	22d. LOCATION (City, town, or county) (State) Valdese N. Carolina
23. FUNERAL DIRECTOR'S SIGNATURE Levinson Bros. ADDRESS 1661- Wood Hope Rd SE WASH. D.C.		24a. REC'D BY REGISTRAR JUN 4 1957	24b. REGISTRAR'S SIGNATURE Carmel Campbell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 4 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the cause of the delay in the space provided. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

6686

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06696

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 1238 Trinidad Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Meadow Middle Forster Last Tucker				4. DATE OF DEATH Month June Day 9 Year 1957			
5 SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-14-16	
9 AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitorial service				10b. KIND OF BUSINESS OR INDUSTRY Custodian		11. BIRTHPLACE (State or foreign country) N. Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Dorsey Napper				14. MOTHER'S MAIDEN NAME Eva McCullough			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Pearl Hendricks Tucker; Beaver Heights, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 816 X DUE TO Conditions, if any, which gave rise to immediate cause (b) Severence of thoracic aorta. (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Passenger in automobile in collision with another automobile.			
20c. TIME OF INJURY Month, Day, Year 11:50 p.m. 6-8-57 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Glenn Dale, Pr. Geo. Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney EXAMINER'S NAME (Type) John T. Maloney, M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED June 9, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/12/ 1957		22c. NAME OF CEMETERY OR CREMATORY Lincoln		22d. LOCATION (City, town, or county) (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Stewart ADDRESS 30 H. St. N.E.				24a. REC'D BY REGISTRAR JUN 12 '57		24b. REGISTRAR'S SIGNATURE Paul Smith	

RECEIVED

JUN 12 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6687 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06697

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN 1b 4 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Sheree Middle Lee Last Walker				4. DATE OF DEATH Month June Day 5 Year 19 57			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 21, 1956	
9. AGE (in years last birthday) 1 yrs.		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.		IF UNDER 24 HRS. Months 1 Days 1 Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) District of Columbia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Preston Walker				14. MOTHER'S MAIDEN NAME Shirley Elwood			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. -----		17. INFORMANT Father; same address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 417.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2nd degree burns of about 60 % of the body DUE TO (c) -----							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Mother was bathing child in bathtub. Called out of the room. Child opened hot faucet.							
20c. TIME OF INJURY Month, Day, Year Hour 7:00 P.M. 6-1- 19 57				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) College Park				20g. (County) Pr. Geo.		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				DATE SIGNED June 6, 1957			
NAME (Type) John T. Maloney, M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 9, 1957		22c. NAME OF CEMETERY OR CREMATORY Stamford Cemetery		22d. LOCATION (City, town, or county) Stamford, N. Y.	
23. FUNERAL DIRECTOR'S SIGNATURE F. GASCH'S SONS				ADDRESS Hyattsville, Maryland		24a. REC'D BY REGISTRAR JUN 10 1957	
24b. REGISTRAR'S SIGNATURE James J. Leary							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

JUN 10 1957

BUREAU V. S.

6688

CERTIFICATE OF DEATH

06698

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Prince Georges				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Choverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 34 Brentwood			
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last May E. Walters				4 DATE OF DEATH Month Day Year June 21 19 57			
5 SEX Female		6 COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 4/19/1882	
9 AGE (In years last birthday) 75 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work				10b KIND OF BUSINESS OR INDUSTRY at home			
11 BIRTHPLACE (State or foreign country) Tyron, Pa.				12 CITIZEN OF WHAT COUNTRY? U.S.			
13 FATHER'S NAME Astbury Bryan				14 MOTHER'S MAIDEN NAME Mary Ellen Snyder			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16 SOCIAL SECURITY NO. 171-07-9936			
17 INFORMANT Address 44513-5th Ave. Riverdale, Md.				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS				INTERVAL BETWEEN ONSET AND DEATH 4 weeks			
DUE TO (b) CORONARY ARTERIOSCLEROSIS				2 years			
DUE TO (c) GENERALIZED ARTERIOSCLEROSIS				5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUT NG TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 6/11, 1957, to 6/21, 1957, that I last saw the deceased alive on 6/21, 1957, and that death occurred at 2:30 PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE Norman Donat Ameau M.D.				ADDRESS (Street, city or town, state) 3503 Penny St. DATE SIGNED 6/21/57			
PHYSICIAN'S NAME (Type) NORMAN DONAT AMEAU M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 6-25-57		22c. NAME OF CEMETERY OR CREMATORY Fairview		22d. LOCATION (City, town or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE JUN 25 1957			
24b. REGISTRAR'S SIGNATURE							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 72 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars name, to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 25 1957

BUREAU V. E.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 1, 2 FilmC: 17 7-2-57 et

6718

CERTIFICATE OF DEATH

06699

Reg. Dist. No. 2456.12

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Prince George</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Prince George</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Seat Pleasant</u>		<u>2 yrs</u>		TOWN <u>Seat Pleasant</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<u>1 7272 Kobb St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Rosa Washington</u>				<u>June 25, 1957</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS
<u>F</u>	<u>AA</u>	<u>Widowed</u>	<u>12-9-91</u>	<u>65</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired]		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Domestic</u>				<u>Wash., D.C.</u>		<u>U.S.A</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John Ruffin</u>				<u>Annie Anderson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A)						<u>1 day</u>	
ANTECEDENT CAUSE(S) DUE TO						<u>15 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B)							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-2</u> , 19 <u>57</u> , to <u>6-23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6-24</u> , 19 <u>57</u> , and that death occurred at <u>10:50 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>D. Stuber Marshall</u>				M.D. <u>2712</u>		DATE SIGNED <u>6-26-57</u>	
ADDRESS (Street, city, town, state) <u>P St., N.W.</u>				(State)			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>6-28-57</u>		<u>Washington National Cemetery Ft. Meade Va.</u>			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Alfred</u>				<u>H. East</u>		<u>1424 2nd St. N.W.</u>	
DATE <u>Jun 28 '57</u>							

RECEIVED

JUN 28 1957

BUREAU V. 81

6689

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06700

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 24 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. STREET ADDRESS Upshur Street	
3. NAME OF DECEASED (Type or print) First Middle Last Francis Ivy Brown Watson		4. DATE OF DEATH Month Day Year June 17 1957	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9, 1919
9. AGE (In years last birthday) 37 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Junk	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ram Brown		14. MOTHER'S MAIDEN NAME Carrie Press	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Theodore Watson; same address		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exhaustion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hemorrhage and shock DUE TO (c) Gunshot wound of abdomen			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot by another person while playing dice.	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 5-25- 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> yard.	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Bladensburg Pr. Geo. Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>John T. Maloney</i>		DATE SIGNED June 18, 1957	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-21-57	22c. NAME OF CEMETERY OR CREMATORY African Bapt. Church Cemetery	22d. LOCATION (City, town, or county) (State) Cheriton Virginia
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co. 901 3rd St., S. W.		24a. REC'D BY REGISTRAR JUN 20 '57	
24b. REGISTRAR'S SIGNATURE <i>Alfred</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed in 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

JUN 20 1957

RECEIVED

6690

CERTIFICATE OF DEATH

06701

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md. c. LENGTH OF STAY IN 1b 1 Day 20 Min. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George Hospital		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY PG. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant d. STREET ADDRESS 1001 61st. Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Wilbur Wilson		4. DATE OF DEATH Month Day Year June 4 1957	
5 SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-27-91
9. AGE (in years last birthday) 65 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Dennis Wilson		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hortense Wilson Wife		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Thrombosis of Basal Ganglia (Left) 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 days unknown		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 2nd 1957 to June 3, 1957 , that I last saw the deceased alive on June 3, 1957 , and that death occurred at 7:10 P.M. from the causes and on the date stated above. Max M. Herzberg ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Max M. Herzberg M.D.		PHYSICIAN'S NAME (Type) Dr. Max Herzberg	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 8, 1957	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	22d. LOCATION (City, town, or county) (State) D.C.
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Stewart ADDRESS 30 H St. NE		24a. REC'D BY REGISTRAR DATE JUN 10 57	24b. REGISTRAR'S SIGNATURE Overman

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6719

CERTIFICATE OF DEATH

06702

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges'			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Naylor			c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Naylor		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Tanyard Road				d. STREET ADDRESS Tanyard Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lillian Middle Agnes Last Windsor				4. DATE OF DEATH Month June Day 5 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 2, 1884	
9. AGE (In years last birthday) 73 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME John Richardson				14. MOTHER'S MAIDEN NAME Margaret Ellen Burch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No.		16. SOCIAL SECURITY NO. ---		17. INFORMANT Thomas Don Windsor Address Naylor, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized DUE TO (c) Myocardial Infarctus						INTERVAL BETWEEN ONSET AND DEATH 4 days 8 yrs 16 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Mar 1947 to June 3, 1957 , that I last saw the deceased alive on 3 June 1957 , and that death occurred at 11 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Upper Marlboro, Maryland DATE SIGNED 6/6/57 ACTUAL SIGNATURE R. B. Sasscer M.D. PHYSICIAN'S NAME (Type) R. B. Sasscer, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/8/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		22d. LOCATION (City, town, or county) (State) Upper Marlboro, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home-Marlboro, Md.				24a. REC'D BY REGISTRAR JUN 10 1957		24b. REGISTRAR'S SIGNATURE H. R. Reddy	

BUREAU V. S.

1917

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar's signature to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 229

06703

6691

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hanover	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sandy Spring Road		d. STREET ADDRESS 02X02	
3. NAME OF DECEASED (Type or print) Janie First Fredelia Middle Youse Last		4. DATE OF DEATH June 8, 1957 19	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 18, 1885
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Franklin Harding		14. MOTHER'S MAIDEN NAME Rachel Waters	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Miss Henrietta Youse		Address Hanover, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153X Carcinoma Liver - Colon DUE TO Trauma - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma Sigmoid (operation 1952) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 mo.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 2 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-15, 1957, to 6-8, 1957, that I last saw the deceased alive on 6-8, 1957, and that death occurred at 2:40 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE M.B. Steward		ADDRESS (Street, city or town, state) DATE SIGNED 314 Compton Ave. Landover, Md. 1957	
PHYSICIAN'S NAME (Type) K.B. STEWARD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/11/57	
22c. NAME OF CEMETERY OR CREMATORY Trinity Meth. Church Cem.		22d. LOCATION (City, town, or county) (State) Patuxent, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE IN 14 1957	
24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

<p>1. Name of deceased</p>		<p>2. Sex</p>		<p>3. Race</p>	
<p>4. Date of birth</p>		<p>5. Date of death</p>		<p>6. Place of death</p>	
<p>7. Cause of death</p>		<p>8. Manner of death</p>		<p>9. Signature of physician</p>	
<p>10. Signature of registrar</p>		<p>11. Signature of informant</p>		<p>12. Date of registration</p>	

BUREAU V. R.

JUN 14 1967

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6620

CERTIFICATE OF DEATH

06704

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3426 Newton Street</u>		d. STREET ADDRESS <u>3426 Newton Street</u>	
3. NAME OF DECEASED (Type or print) <u>Olle Florence Ziebler</u>		4. DATE OF DEATH <u>June 7 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 16, 1871</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lucius Marion Morris</u>		14. MOTHER'S MAIDEN NAME <u>Mary Barrett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Edna R. Chapman</u>		Address <u>3426 Newton Mt. Rainier Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>321X</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>October 1950</u> to <u>June 7 1957</u> , that I last saw the deceased alive on <u>June 7 1957</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles E. Woodson</u> M.D.		ADDRESS (Street, city or town, state) <u>1801 Eye St. N.W. Wash. D.C.</u>	
PHYSICIAN'S NAME (Type) <u>CHARLES E. WOODSON</u>		DATE SIGNED <u>6/11/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/10/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley's Funeral Home</u>		ADDRESS <u>Mt. Rainier Md.</u>	
24a. REC'D BY REGISTRAR <u>JUN 11 1957</u>		24b. REGISTRAR'S SIGNATURE <u>James H. Kelly</u>	

CERTIFICATE OF DEATH

[Faint, mostly illegible text from the certificate form, including fields for name, date, and cause of death.]

BUREAU V. S.

JUN 11 1957

RECEIVED